Erfassung und Behandlung von Jugendlichen mit einer Identitätsstörung

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Emanuel Jung

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auf Antrag von

Prof. Dr. phil. Jens Gaab
Prof. Dr. med. Dipl.-Psych. Klaus Schmeck

Basel, den _____

_____
Prof. Dr. Roselind Lieb
Dekanin

UNI
BASEL

Erfassung und Behandlung von Jugendlichen mit einer Identitätsstörung

Emanuel Jung
Fakultät für Psychologie
Universität Basel

Übersichtsarbeit der kumulativen Dissertation mit 3 Artikeln

Assessment of identity development and identity diffusion in adolescence
Goth et al., 2012a

Identity development in adolescents with mental problems
Jung et al., 2013

Assessment and treatment of identity pathology during adolescence
Schlüter-Müller et al., in press

Mitglieder der Promotionskommission

Prof. Dr. phil. Jens Gaab
Betreuer, Psychologische Fakultät der Universität Basel

Prof. Dr. med. Dipl.-Psych. Klaus Schmeck
Medizinische Fakultät der Universität Basel

Prof. Dr. rer. nat. Dipl.-Psych. Rolf-Dieter Stieglitz
Psychologische und medizinische Fakultät der Universität Basel

Abstract (Deutsch)

Die Identitätskonsolidierung ist eine zentrale Entwicklungsaufgabe in der Adoleszenz. Der erfolgreiche Umgang mit Identitätskrisen erlaubt die Positionierung der eigenen Person im sozialen Kontext, den Aufbau von befriedigenden Beziehungen und das Verfolgen von selbstgewählten Lebenszielen. Im Gegensatz dazu fehlt bei einer Identitätsdiffusion die Integration von Konzepten zur eigenen Person und zu bedeutsamen Mitmenschen, was zu einer pathologischen Persönlichkeitsstruktur beitragen kann. Persönlichkeitsstörungen können als überdauernde Beeinträchtigungen von intra- und interpersonellen Funktionsfähigkeiten gesehen werden, welche häufig in der Kindheit und Jugend erstmals in Erscheinung treten. Dabei wird eine klinisch auffällige Identitätsentwicklung als zentral für das ätiologische und pathogenetische Verständnis von Persönlichkeitsstörungen betrachtet. Die Forschungssektion der fünften Revision des „Diagnostic and Statistical Manual of Mental Disorders“ misst dem Konstrukt „Identität“ als Diagnosekriterium für Persönlichkeitsstörungen eine zentrale Bedeutung zu.

Der Fragebogen “Assessment of Identity Development in Adolescence” ist ein reliables und valides Inventar zur dimensionalen Erfassung von gesunder und klinisch auffälliger Identität im Jugendalter. Dieses Selbstbeurteilungsverfahren kann zur Indikation und Evaluation von Therapieverfahren eingesetzt werden, welche auf Identität im therapeutischen Prozess fokussieren.

Die Therapiemethode “Adolescent Identity Treatment” konzentriert sich auf die pathologische Identitätsentwicklung im Jugendalter und verbindet auf einem objektbeziehungstheoretischen Hintergrund Elemente der übertragungsfokussierten Therapie mit verhaltenstherapeutischen und systemischen Therapieansätzen.

Abstract (English)

Identity consolidation is one central task in adolescence. The successful management of identity crises allows the positioning of oneself in a social context, the establishment of satisfying relationships and the pursuit of self-chosen life goals. In contrast, identity diffusion is seen as a lack of integration of the concept of the self and significant others, which contributes to pathological personality structures. Personality disorders can be seen as enduring impairments of intra- and interpersonal functioning, which often occur in childhood and adolescence for the first time. Thereby, identity disturbance is seen as central for the etiologic and pathogenetic understanding of personality disorders. Therefore, the research section of the fifth revision of the "Diagnostic and Statistical Manual of Mental Disorders" attaches importance to the construct of „identity" as a diagnostic criterion for personality disorders.

The questionnaire "Assessment of Identity Development in Adolescence" is a reliable, valid, and time-efficient diagnostic inventory to represent a dimensional concept of healthy and disturbed identity in adolescence. The inventory can serve as a tool for indication and evaluation of treatment methods, which focus on identity. .

Adolescent Identity Treatment is a treatment model that focuses on identity pathology as one core characteristic of personality disorders. This model integrates specific techniques for the treatment of adolescent personality pathology on the background of object-relation theories and modified elements of "Transference-Focused Psychotherapy". Moreover, psychoeducation, behavior-oriented home plans, and family work support the therapeutic process of the adolescent.

Abkürzungsverzeichnis

AIDA	Assessment of Identity Development in Adolescence
AIT	Adolescent Identity Treatment
APA	American Psychiatric Association
BPFS-C	Borderline Personality Features Scale for Children
BPQ	Borderline Personality Questionnaire
CAT	Cognitive Analytic Therapy
DBT	Dialectical Behavior Therapy
DSM	Diagnostic and Statistical Manual of Mental Disorders
ERT	Emotion Regulation Training
FSKN	Frankfurter Selbstkonzeptskalen
ICD	International Classification of Diseases and Related Health Problems
IDQ-A	Identity Disturbance Questionnaire-Adolescent Version
IPO	Inventory of Personality Organisation
IPDE	International Personality Disorder Examination
JTCI	Junior Temperament und Charakter Inventar
K-DIPS	Diagnostisches Interview bei psychischen Störungen im Kindes- und Jugendalter
KJPK	Kinder- und Jugendpsychiatrische Klinik
LOPF-QA	Level of Personality Functioning-Questionnaire for Adolescents
MBT	Mentalization-Based Treatment
OPD	Operationalisierte psychodynamische Diagnostik
PAI	Personality Assessment Inventory
SFT	Schemafokussierte Therapie
SIPP-118	Severity Indices of Personality Problems
SKID-II	Strukturiertes Klinisches Interview für DSM-IV, Achse-II-Störungen
STIPO	Structured Interview for Personality Organization
TAU	Treatment As Usual
TFP	Transference-Focused Psychotherapy

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1. Einleitung

Identität ist in verschiedenen wissenschaftlichen Disziplinen ein breit diskutiertes Konstrukt. Die philosophische Ontologie befasst sich seit dem Schiff des Theseus mit identitätsbezogenen Fragestellungen (Verliert ein Objekt, etwa ein Schiff, seine Identität, wenn alle seine Bestandteile im Laufe der Zeit ersetzt wurden? vgl. Essler, 2001). In der Philosophie ist Identität ein Prädikat, das die Unterscheidung zwischen Objekten ermöglicht resp. auf die Einzigartigkeit eines Objektes verweist (Sollberger, 2013).

Anthropologisch gesehen ist Identität nicht etwas bereits Vorgegebenes, sondern ein Ergebnis von Reflexion und „sozialen Identifizierungspraktiken" (Zirfas, 2014, S. 567).

Der politische und soziologische Identitätsdiskurs setzt sich mit der Ausbildung von individueller und sozialer Identität auf dem Hintergrund von gesellschaftlichen Veränderungen auseinander. Die Konsequenzen der als ‚postmodern' und ‚globalisiert' beschriebenen Veränderungen erschweren die gegenwärtige „Identitätsarbeit" (Keupp & Höfer, 1997). Pluralisierung, Enttraditionalisierung, Dynamisierung des Arbeitsmarktes mit erhöhten Bildungs- und Mobilitätserfordernissen führen zu einer Erosion der sozial vorgegebenen Identitätsmuster (Eickelpasch & Rademacher, 2010). Die Identitätsentwicklung wird in der Folge zunehmend privatisiert und unter Konzepten wie „Bastelexistenz" (Hitzler & Honer, 1994), „Der flexible Mensch" (Sennett, 1998) und „Patchwork-Identität" (Keupp, 2008) beschrieben. Klassische Orientierungspunkte wie Ausbildungsabschluss, Heirat und Elternschaft verschieben sich im Rahmen des gesellschaftlichen Wandels in den westlichen Staaten und führen in der Adoleszenz und im jungen Erwachsenenalter zu einer veränderten Identitätsgenese (vgl. Konzept „Emerging adulthood"; Arnett, 2004). Die Berücksichtigung des veränderten Entwicklungskontexts hat Einfluss auf Fragen wie, welche Zeitgrenzen und Entwicklungsverläufe als normativ und welche als pathologisch anzusehen sind (Seiffge-Krenke, 2012). Eine Zunahme von Identitätsstörungen ist möglicherweise die Folge der gegenwärtigen Transformation von gesellschaftlichen Strukturen, bei der offen bleibt, ob ein Leben mit Identitätsfragmenten in Zukunft eine sinnvolle Anpassungsleistung wird (Ermann, 2011). Zurzeit ist eine fehlende Identitätsintegration in der persönlichen Entwicklung nach wie vor mit grossem Leidensdruck verbunden und oft Gegenstand von Psychotherapie.

Auf dem Hintergrund von solchen gesellschaftlichen Veränderungen fokussiert die psychologisch und psychodynamisch orientierte Identitätsforschung auf die individuelle Identitätsentwicklung, welche durch die Arbeiten von Erikson (1959, 1968) wesentliche Impulse erhielt. Identitätsbildung ist ein lebenslanger Prozess, der in der Adoleszenz im Rahmen der

Identitätskonsolidierung eine zentrale Entwicklungsaufgabe darstellt. Die erfolgreiche Bewältigung von Identitätskrisen ermöglicht die Positionierung der eigenen Person im sozialen Kontext, den Aufbau von befriedigenden Beziehungen zu anderen Personen und das Verfolgen von selbstgewählten Lebenszielen. Im Gegensatz dazu fehlt bei einer Identitätsdiffusion eine grundlegende Integration von Konzepten zur eigenen Person und zu bedeutsamen Mitmenschen, was, begleitet von schmerzhaften Gefühlen von Inkohärenz und Diskontinuität, zur Bildung einer pathologischen Persönlichkeitsstruktur beitragen kann. Persönlichkeitsstörungen können als überdauernde Beeinträchtigungen von intra- und interpersonellen Funktionsfähigkeiten gesehen werden, welche häufig in der Kindheit und Jugend erstmals in Erscheinung treten und während der gesamten Lebensspanne weiterbestehen können. Dabei wird eine klinisch auffällige Identitätsentwicklung als zentral für das ätiologische und pathogenetische Verständnis von Persönlichkeitsstörungen betrachtet. Die Forschungssektion der fünften Revision des DSM (APA, 2013a) misst dem Konstrukt "Identität" als Diagnosekriterium für Persönlichkeitsstörungen entsprechend der zunehmenden Tragweite von Identitätskonzeptionen eine zentrale Bedeutung zu.

Goth und Mitarbeiter[1] (2012a) entwickelten an der Kinder- und Jugendpsychiatrischen Klinik Basel (KJPK) in Kooperation mit einer internationalen Arbeitsgruppe den Fragebogen „Assessment of Identity Development in Adolescence“ (AIDA) für Jugendliche zwischen 12-18 Jahren. Dieses reliable und valide Fragebogeninventar zielt auf die Erfassung gesunder und gestörter Identitätsentwicklung mittels Selbsteinschätzung und kann als Instrument zur Indikation und Evaluation von Behandlungsmethoden dienen, welche Identität zum Fokus haben. „Adolescent Identity Treatment“ (AIT) ist ein solches Therapiekonzept, das spezifisch auf die Identitätsdiffusion und die Überwindung von Entwicklungsblockaden in der Adoleszenz zielt (Foelsch et al., 2013, 2014). Um dies zu erreichen, adaptiert AIT Elemente der übertragungsfokussierten Psychotherapie für die Adoleszenz und verbindet sie mit verhaltenstherapeutischen und systemischen Behandlungsansätzen.

Die vorliegende Übersichtsarbeit der kumulativen Dissertation beschreibt, aufbauend auf dem zugrundeliegenden theoretischen Hintergrund, den Fragebogen AIDA als Diagnoseinstrument und die Therapieform AIT als Behandlungsverfahren für Jugendliche mit einer Identitätsstörung.

[1] Der einfacheren Lesbarkeit dienend wird im Folgenden bei geschlechtsspezifischen Substantiven wie „Mitarbeiter“, „Patient“ oder „Therapeut“ nur die männliche Schreibweise verwendet, die weibliche Schreibweise ist aber immer mitgemeint.

2. Theoretischer Hintergrund

2.1 Identität, Identitätskrise und Identitätsdiffusion

Nach Erikson (1959, 1978) ist Identität ein fundamentales Organisationsprinzip, das Menschen ein Gefühl von transtemporaler Beständigkeit vermittelt und einen Rahmen zur Differenzierung zwischen der eigenen Person und anderen bereitstellt. Sie ergibt sich aus dem Zusammenspiel von Ich-Funktionen einerseits und der emotionalen Verbundenheit mit der Gemeinschaft andererseits. „Identität, das ist der Schnittpunkt zwischen dem, was eine Person sein will, und dem, was die Umwelt ihr gestattet“ (Erikson, 1959 zit. nach Seiffge-Krenke, 2012, S. 10).

Verschiedene Autoren haben aufbauend auf den Arbeiten von Erikson das Identitätskonzept weiter differenziert und deren Komponenten bestimmt (vgl. Akthar & Samuel, 1996). Dabei werden Termini wie „Ich“, „Ich-Identität“, „Selbst“, „Selbstkonzept“ und „Mentale Repräsentationen“ uneinheitlich verwendet (vgl. Erikson, 1978; Kroger, 1996). Mit Bezug auf James (1890) und Mead (1934) können mit dem (englischen) „I“ und „Me“ zwei grundlegende Identitätsaspekte unterschieden werden. „I“ entspricht einer intuitiv und emotional direkt erfahrbarbaren Selbstevidenz und verweist auf die eigene Wesensgleichheit bei kontinuierlicher Veränderung über die Zeit. „Me“ beruht auf einem selbstreflexiven Prozess und enthält kognitiv abrufbares Wissen über sich selbst. Dieser Unterteilung folgend unterteilt sich Identität in zwei übergeordnete Konstrukte: Die subjektive Selbstidentität, welche emotional erfahrbar auf Kontinuität fokussiert und die definitorische Selbstidentität mit einem kognitiven und narrativen Zugang sowie einem Fokus auf Kohärenz (vgl. Resch, 2005; Goth et al., 2012a; Foelsch et al., 2013). Entsprechend definiert Ermann (2011, S. 135) Identität als ein Empfinden von „Kohärenz und Kontinuität im Kontext der sozialen Bezogenheit“.

Stern (1985, 1992) beschreibt vier Grunderfahrungen des Kernselbst (Urheberschaft, Selbst-Kohärenz, Selbst-Affektivität und Selbst-Geschichtlichkeit), wobei er später (Stern, 1998) eine Reduktion auf drei Grunderfahrungen mit einer Subsumierung der Selbst-Affektivität und einer Änderung von „Selbst-Geschichtlichkeit“ in „Selbst-Kontinuität“ vorschlägt.

Marcia (1966, 2006) unterscheidet vier Identitätszustände (Moratorium, erarbeitete, übernommene und diffuse Identität), welche Varianten im Umgang mit der Aufgabe, eine eigene Identität zu bilden, widerspiegeln.

Fonagy und Mitarbeiter (2002) integrierten psychodynamische und bindungstheoretische Auffassungen mit der „Theory of mind“ zum Konzept der Mentalisierung, welches die Fähigkeit

beschreibt, eigenes und fremdes Verhalten auf dem Hintergrund der Zuschreibung von mentalen Zuständen zu verstehen. Gelingende Identitätsentwicklung basiert auf der Fähigkeit, mentalisieren zu können (Foelsch et al., 2013). Bei Kleinkindern (und bei Patienten mit einer Identitätsstörung) ist die Fähigkeit, zu mentalisieren und adäquat zwischen Innen und Aussen zu unterscheiden, gering ausgeprägt, sodass Erfahrungen des täglichen Lebens wiederkehrend überfordernd erlebt werden. Da Überforderungen Bestandteile jeder Identitätsentwicklung sind, ist es klinisch bedeutsam, zwischen einer zur normalen Entwicklung gehörenden Identitätskrise und einer pathologischen Identitätsdiffusion unterscheiden zu können.

Identitätskrise

Nach Erikson (1959) fordert besonders die Adoleszenz den jungen Menschen heraus, frühere Introjektionen und Identifikationen im Rahmen von Identitätskrisen zu verwerfen, zu transformieren und zu einer Identität zu integrieren. Die dabei stattfindende Metamorphose der adoleszenten psychischen Struktur bezeichnete Blos (1967, 1979) als „zweite Individuation", in der Konflikte der Kindheit aktualisiert und neu gelöst werden. Dabei beinhaltet die Entidealisierung von sich selbst und anderen wichtigen Bezugspersonen einen schmerzlichen Prozess. Nach Kernberg (1978) entstehen Identitätskrisen durch die wahrgenommene Diskrepanz zwischen dem sich rasch wandelnden Selbst und der grösser werdenden Kluft zwischen Selbst- und Fremdwahrnehmung. Sie treten in der Adoleszenz typischerweise im Zusammenhang mit Berufswahl, Intimität und körperlicher Veränderung auf. Die erfolgreiche Krisenbewältigung führt, verbunden mit einem gefestigten Gefühl von Kohärenz und Kontinuität, zu einer integrierten Identität, welche sich in adäquater Beziehungsgestaltung und klaren Perspektiven widerspiegelt. Identitätskrisen können unterschiedlich stark ausgeprägt sein und sind in ihrer belastendsten Form nur schwer von Identitätsdiffusion zu unterscheiden (vgl. Foelsch et al., 2013).

Identitätsdiffusion

Im Gegensatz zu Identitätskrisen, die ein normaler Bestandteil der adoleszenten Entwicklung darstellen und bei der – trotz phasenweiser Destabilisierung – das Gefühl der eigenen Kohärenz und Kontinuität bestehen bleibt, fehlt bei einer Identitätsdiffusion die grundlegende Integration von Konzepten zur eigenen Person und zu bedeutsamen Mitmenschen. Dies führt sowohl zu schmerzhaften Gefühlen von Inkohärenz und innerer Leere als auch zu Schwierig-

keiten, sich selbst zu definieren, an Zielen festzuhalten und Beziehungen zu anderen Menschen aufzubauen (Clarkin et al., 2008). Klinisch zeigt sich die Identitätsdiffusion in einer widersprüchlichen und chaotischen Beschreibung der eigenen Person und einem Unvermögen, Ambivalenzen wahrzunehmen und auszuhalten (Kernberg, 1985; Clarkin, et al., 2008). Zusammenfassend schlagen Foelsch und Mitarbeiter (2010) vor, in einem Erstgespräch mit Jugendlichen auf folgende Kriterien zu achten, um eine Identitätsdiffusion von einer Identitätskrise zu unterscheiden:

- chaotische Selbst- und Fremdbeschreibung,
- fehlende Integration von Selbst- und Objektrepräsentation,
- defizitäre Autonomiefunktionen,
- kaum überwundene Separations- und Individuationsphase,
- Unvermögen für sich eine eigene Entwicklungsperspektive zu denken,
- nicht integriertes Über-Ich,
- Überidentifikation mit Gruppen oder Rollen und
- quälendes Gefühl von Inkohärenz.

Die Konzepte der Identitätsdiffusion im Jugendalter und im Erwachsenenalter sind ähnlich. Paulina Kernberg (2001a) modifizierte die von Otto Kernberg spezifisch zur Behandlung von erwachsenen Patienten mit einer Identitätsdiffusion entwickelte „Transference-Focused Psychotherapy“ (TFP; Deutsch: Übertragungsfokussierte Psychotherapie, Clarkin, et al., 2008) für das Jugendalter. Sie legte bei jugendlichen Patienten grossen Wert auf die diagnostische Unterscheidung zwischen Identitätskrise und Identitätsdiffusion, um therapeutische Massnahmen gezielt einsetzen zu können. Eine schweizerisch-deutsch-amerikanische Arbeitsgruppe um Foelsch und Mitarbeiter (2013) setzt die Arbeit von Paulina Kernberg fort und entwickelte den AIDA-Fragebogen zur Erfassung von unauffälliger, krisenhafter und diffuser Identität sowie die Behandlungsform AIT zur Behandlung von Jugendlichen mit einer Identitätsdiffusion.

Die theoretischen Überlegungen zur Diagnostik und Therapie von Identitäts- und Persönlichkeitsstörungen erfolgen nachstehend vor der Darstellung des Fragebogeninventars AIDA (siehe Kapitel 3) und der Therapieform AIT (siehe Kapitel 4).

2.2 Diagnostik von Identitätsstörungen im Kindes- und Jugendalter

Die Identitätsstörung gilt als zentrales Merkmal von (Borderline-)Persönlichkeitsstörungen und findet sich folglich in verschiedenen Klassifikationssystemen als Diagnosekriterium von Persönlichkeitsstörungen wieder.

Kategoriale Diagnoseverfahren wie ICD-10 (Dilling et al., 2005), DSM-IV-TR (APA, 2000) oder DSM-5 (APA, 2013a) gehen davon aus, dass Persönlichkeitsstörungen in voneinander abgrenzbare Diagnosegruppen eingeteilt werden können. Zur Diagnostik werden Interviews wie das „Strukturierte Klinische Interview für DSM-IV, Achse-II-Störungen“ (SKID-II, Fydrich et al., 1997) oder die „International Personality Disorder Examination“ (IPDE; Mombour et al., 1996) verwendet, wobei bei Jugendlichen einzelne Fragen an deren Lebenskontext angepasst werden sollten (Salbach-Andrae et al., 2008). Die Identitätsstörung („Identity disturbance“) ist im DSM-5 das 3. Diagnosekriterium der Borderline-Persönlichkeitsstörung und wird als deutliche und anhaltende Instabilität im Selbstbild definiert (APA, 2013a). Becker und Kollegen (2002) zeigten, dass von den Diagnosekriterien die Identitätsstörung der stärkste Prädiktor für Borderline-Persönlichkeitsstörungen im Jugendalter ist.

Die einseitig kategoriale Klassifikation ist aufgrund hoher Überschneidung der einzelnen Persönlichkeitsstörungen, grosser Heterogenität der Patienten in derselben Kategorie sowie geringer konvergenter Validität fraglich (Livesley, 2003; vgl. Schmeck et al., 2013a). Im Vorfeld der Revision des DSM-IV-TR wurde eine Kombination aus kategorialer und dimensionaler Persönlichkeitserfassung vorgeschlagen, welche aber im neuen DSM-5 aufgrund zu hoher Komplexität keine Aufnahme in den Hauptteil fand. Stattdessen übernahm das DSM-5 die Klassifikationsweise vom DSM-IV-TR (bis auf den Wechsel zum Ein-Achsen-System) und empfahl das alternative Modell in der Sektion III des Manuals zur weiteren Forschung (APA, 2013b).

Nach dem alternativen Modell reduziert sich die Anzahl der spezifischen Diagnosen von bisher zehn auf folgende sechs: Antisoziale, vermeidende, narzisstische, zwanghafte, schizotypische und Borderline-Persönlichkeitsstörung. Eine Kombination von Beeinträchtigungen in einerseits Persönlichkeitsfunktionen und andererseits klinisch auffälligen Persönlichkeitsmerkmalen (Negative Affectivity, Detachment, Antagonism, Disinhibition und Psychoticism) soll zur Feststellung dieser Diagnosetypen dienen. Die „Level of Personality Functioning Scale“ erfasst erstere jeweils auf einer Skala von 0-4 (keine bis extreme Beeinträchtigung) und unterscheidet zwischen selbstbezogenen (Identität und Selbstlenkung) und interpersonellen Persönlichkeitsfunktionen (Empathie und Intimität). Identität erhält in diesem

alternativen Modell einen wichtigen Stellenwert und wird wie folgt definiert: “Experience of oneself as unique, with clear boundaries between self and others; stability of self-esteem and accuracy of self-appraisal; capacity for, and ability to regulate, a range of emotional experience” (APA, 2013a, S. 762). Aktuell bestehen Bestrebungen der Forschungsgruppe an der KJPK mit dem Fragbogeninventar „Level of Personality Functioning-Questionnaire for Adolescents“ (LoPF-QA) alle vier Persönlichkeitsfunktionsbereiche in der Selbstbeurteilung mit hoher Güte zu erfassen (Schrobildgen et al., 2014). Ein dimensionales Instrument, das Komponenten von Persönlichkeitsfunktionen ebenfalls – jedoch nicht deckungsgleich zum alternativen DSM-5-Modell – aufgreift, ist der Selbstbeurteilungsfragebogen „Severity Indices of Personality Problems“ (SIPP-118) mit den Komponenten „Self-control“, „Identity integration“, „Relational capacities“, „Social concordance“ und „Responsibility“ (Verheul et al., 2008; Feenstra et al., 2014).

Diagnoseinstrumente, welche Identitätsaspekte miterfassen, zielen oft auf Kriterien der emotional-instabilen resp. Borderline-Persönlichkeitsstörung, da bei ihr die Identitätsstörung ein prominentes Merkmal ist (siehe Jung et al., 2012 für eine Diskussion von Fragebogen- und Interviewverfahren von Persönlichkeitsstörung im Allgemeinen sowie der Kontroverse bezüglich der Diagnosestellung in der Adoleszenz). Westen und Mitarbeiter (2011) entwickelten mit dem „Identity Disturbance Questionnaire-Adolescent Version“ (IDQ-A) ein Instrument für Kliniker zur Erfassung von Identitätsstörung im Jugendalter mit den Dimensionen: „Lack of normative commitment“, „Role absorption“, „Painful incoherence“ und „Lack of consistency“.

Entsprechend den Diagnosekriterien des DSM-IV-TR entwickelten Poreh und Kollegen (2006) den „Borderline Personality Questionnaire“ (BPQ), der eine zufriedenstellende Testgüte besitzt (Chanen et al., 2008a; Fonseca-Pedrero et al., 2011) und zur Erfassung von Borderline-Persönlichkeitsstörung in der Selbstbeschreibung für Jugendliche und junge Erwachsene dient. Der BPQ besitzt neun Subskalen („Impulsiveness“, „Affective Instability“, „Abandonment“, „Relationship“, „Self-Image“, „Suicide/Self-Mutilation“, „Emptiness“, „Intense Anger“ und „Quasi-Psychotic States“), welche den übergeordneten Skalen „Identity/interpersonal“ und „Impulsivity“ zugeordnet werden.

Aufbauend auf Moreys (1991) Konzept des „Personality Assessment Inventory (PAI) für Erwachsene erarbeiteten Crick und Mitarbeiter (2005) die dimensionale „Borderline Personality Features Scale for Children“ (BPFS-C) mit vier Skalen („Affective instability“, „Identity problems“, „Negative relationships“ und „Self harm“) und hoher psychometrischer Güte (Chang et al., 2011). Im deutschsprachigen Raum sind die Frankfurter Selbstkonzeptskalen

(FSKN; Deusinger 1986) bekannt, welche zur Identitätserfassung eingesetzt werden können (Modestin & Erni, 2000).

Psychodynamisch orientierte Psychotherapierichtungen entwickelten Alternativen zu den gängigen Klassifikationssystemen DSM und ICD. Die „Operationalisierte psychodynamische Diagnostik“ (OPD-2; Arbeitskreis OPD, 2009) sowie die Adaption für das Kinder- und Jugendalter OPD-KJ (Arbeitskreis OPD-KJ, 2007) sind multiaxiale Systeme, welche identitätsbezogene Schwierigkeiten auf mehreren Achsen aufgreifen. Der „Identitätskonflikt“ wird auf der Konflikt- und die Identitätsdiffusion auf der Struktur-Achse abgebildet, wobei letztere als tiefgreifender eingestuft wird.

Das psychoanalytische Nosologie-Modell von Otto Kernberg (Clarkin, et al., 2008) klassifiziert Patienten mit einer Persönlichkeitsstörungen anhand der Dimensionen „Temperamentsausprägung“ (Intro- und Extraversion), Störungsschweregrad (leicht bis schwer) und „Persönlichkeitsorganisationsniveau“ (neurotisch, borderline und psychotisch). Die Identitätsdiffusion ist das Hauptmerkmal der Borderline-Persönlichkeitsorganisation. Die Diagnostik erfolgt anhand des „Strukturellen Interviews“ (Buchheim, et al., 2006), welches durch das „Structured Interview for Personality Organization“ (STIPO; Clarkin et al., 2004; deutsche Übersetzung Döring et al., 2004) im Beurteilungsprozess vereinfacht und in der psychometrische Güte erhöht wurde. Das „Personality Assessment Interview“ (Kernberg, 2001a) ist eine Modifikation des „Strukturellen Interviews“ für den Kinder- und Jugendbereich und erfasst die Fähigkeit zur Reflexion und Empathie sowie die innere Welt von jungen Patienten mit ihren prägenden Selbst- und Objektrepräsentanzen (Schmeck & Schlüter-Müller, 2009). Das Selbstbeurteilungsinstrument „Inventory of Personality Organisation“ (IPO, Clarkin et al., 1998; IPO-CH für Kinder- und Jugendliche von Kernberg, 2001b) dient als Screening für den STIPO, das jedoch aufgrund der geringen psychometrischen Güte nur mit Vorbehalt eingesetzt werden sollte. Hingegen weisen anderssprachige IPO-Version und die deutschsprachige Kurzskala IPO-16 bessere Kennwerte auf (Zimmermann et al.,2013; Dammann et al., 2012) .

2.3 Therapie von Identitäts- und Persönlichkeitsstörungen im Kindes- und Jugendalter

Ähnlich wie bei der Diagnostik dienten Erfahrungen mit erwachsenen Patienten mit einer Identitäts- und Persönlichkeitsstörung als Hintergrund für die Entwicklung von spezifischen Therapieverfahren für Kinder- und Jugendliche. Therapieprogramme für Erwachsene, welche mehrheitlich für die Behandlung von Patienten mit einer emotional-instabilen Persönlichkeits-

störung konzipiert sind, sind meist selbst Modifikationen von etablierten Therapieverfahren. Dabei findet eine zunehmende Integration unterschiedlicher Therapieansätze statt. Für den Erwachsenenbereich liegen folgende manualisierte Therapieverfahren vor (vgl. Schlüter-Müller et al., 2014):

- Dialektisch-Behaviorale Therapie (DBT; Linehan, 1989, 2007)
- Mentalisierungsbasierte Therapie (MBT; Allen & Fonagy, 2009)
- Übertragungsfokussierte Psychotherapie (TFP; Clarkin et al., 2008)
- Kognitiv-Analytische Therapie (CAT; Ryle, 1997)
- Schemafokussierte Therapie (SFT; Young et al., 2005)
- Strukturbezogene Therapie (Rudolf, 2004)
- Kognitive Therapie von Persönlichkeitsstörungen (Beck & Freeman, 1990)

Folgende Therapieprogramme sind für das Kinder- und Jugendalter manualisiert:

- Dialektisch-Behaviorale Therapie für Adoleszente (DBT-A; Miller & Rathus, 2007; Fleischhaker, 2011)
- Mentalisierungsbasierte Therapie für Adoleszente (MBT-A; Rossouw & Fonagy, 2012)
- Kognitiv-Analytische Therapie für Adoleszente (Chanen et al., 2008b)
- Emotion Regulation Training (ERT; Schuppert et al., 2012)
- Adolescent Identity Treatment (AIT ; Foelsch et al., 2013).

Nach Bateman und Fonagy (2000) sollte Psychotherapie bei Patienten mit einer Persönlichkeitsstörung allgemein auf einer tragfähigen therapeutischen Beziehung aufbauen, längerfristig geplant sein, aktiv durch den Therapeuten strukturiert werden und einen klaren Behandlungsfokus beinhalten. Grundsätzlich ist ein ambulantes Setting mit kurzzeitigen stationären Kriseninterventionen sinnvoll. Bei längerer Hospitalisationsdauer kann regressives Verhalten der Patienten die Behandlung erschweren (Schmeck et al., 2009).
Psychodynamisch orientierte Therapieverfahren wie AIT bauen auf objektbeziehungs- und bindungstheoretischen Überlegungen auf, die im Hinblick auf die Entwicklung von Psychopathologie den frühen Interaktionen mit versorgenden Bezugspersonen entscheidende Bedeutung beimessen. Mentale Selbst- und Objektrepräsentationen bilden sich im Rahmen von prototypischen Beziehungserfahrungen mit intensiver affektiver Beteiligung, welche als posi-

tiv (im Sinne von lustvoll und befriedigend) oder negativ (im Sinne von schmerzhaft und frustrierend) erlebt werden und motivational aufsuchendes resp. vermeidendes Verhalten mitbedingen, um das Überleben zu sichern. Objektbeziehungsdyaden bilden sich aus dem charakteristischen Zusammenspiel von Selbstrepräsentanz, Objektrepräsentanz und verbindendem Affekt. Diese internalisierten Dyaden bilden die Basis psychischer Struktur und Identität, welche im normalen Entwicklungsverlauf durch die Integration von negativen und positiven Selbst- und Objektrepräsentanzen an Komplexität gewinnt und die Einsicht widerspiegelt, dass Individuen sowohl negative als auch positive Attribute besitzen. Bei der Selbstgenese von Patienten mit einer Borderline-Persönlichkeitsstörung fehlt dieser integrative Prozess. Positive, idealisierte Repräsentanzen bleiben von negativen, verfolgenden Repräsentanzen gespalten, was zu einer Identitätsdiffusion führt (Clarkin et al., 2008).

3. Diagnostik mit AIDA

Der Fragebogen AIDA (Assessment of Identity Development in Adolescence) dient der Erfassung der Identitätsentwicklung im Jugendalter in der Selbstbeurteilung. Er soll, entsprechend den Überlegungen von Paulina Kernberg (2001a), zwischen unauffälliger Identitätsentwicklung, einer Identitätskrise und einer Identitätsdiffusion differenzieren und gleichzeitig die psychometrischen Schwächen bestehender Instrumente wie dem IPO-CH (Kernberg, 2001b) überwinden. Eine Untersuchung der Literatur zeigt, dass bestehende Instrumente zur Identitätserfassung mehrheitlich in Interviewform, als Expertenrating, für Erwachsene und mit einseitiger Fokussierung auf gesunde oder pathologische Identitätsaspekte vorliegen. Oft besteht eine Konfundierung mit allgemeinen Persönlichkeitsmerkmalen, die nicht dem pathologischen Konstrukt zugehören. So macht es einen Unterschied, ob man seine Freizeitaktivitäten und Lebensziele aufgrund eines impulsiven Temperaments, unterschiedlichen Rollen in verschiedenen Peergroups oder einer fehlenden inneren Kontinuität wechselt (vgl. Goth et al., 2012a).

Die Skalenkonstruktion des AIDA erfolgte theoriegeleitet, integrierte verschiedene elaborierte Identitätstheorien und zielte auf eine Testkonstruktion mit Hauptskalen, Subskalen und Facetten, wovon deduktiv repräsentative Items abgeleitet wurden. Dieses methodische Vorgehen strebte eine Erhöhung der Konstruktvalidität und der Aussagekraft der resultierenden Ergebnisse an (Goth et al., 2012b; Amelang & Zielinski, 1997). Aufbauend auf einer Integration bestehender Identitätstheorien und der grundlegenden Unterscheidung von „Kohärenz“ und „Kontinuität“ (vgl. Kap. 2.1) unterscheidet der AIDA die beiden Hauptskalen „Identitäts-

Kontinuität vs. -Diskontinuität“ und „Identitäts-Kohärenz vs. -Inkohärenz“ die gemeinsam die übergeordnete Skala „Identitäts-Integration vs. Identitäts-Diffusion“ ergeben. Eine weitere inhaltliche Differenzierung erfolgt anhand dreier psychosozialer Funktionsbereiche (selbst-bezogen, sozial-bezogen und mentale Repräsentationen), was die hybride Struktur bestehend aus intra- und interpersonellen Identitätsaspekten sowie die Konzeptualisierung der Mentalisierung aufgreift (vgl. Tabelle 1).

Tabelle 1: Hypothetische, theoriebasierte Dimensionalität des Konstrukts “Identitäts-Integration vs. Identitäts-Diffusion” und die Operationalisierung im AIDA auf Skalen-, Subskalen- und Facettenebene. Zugeordnete selbstbezogene (intrapersonal), sozialbezogene (interpersonal) und reflexionsbezogene Funktionsbereiche (aus Goth et al., 2012b, S. 3)

Gesamtskala Identitäts-Integration vs. Identitäts-Diffusion		
Skala 1 Identitäts-Kontinuität vs. **Diskontinuität** *Ich-Stabilität,* *intuitiv-emotionales „I“*	Skala 2 Identitäts-Kohärenz vs. **Inkohärenz** *Ich-Stärke,* *einheitlich-definiertes „Me“*	Psychosozialer Funktionsbereich
Sub 1.1 **Stabilität in Eigenschaften** und Zielen vs. Fehlende Perspektive F1: Engagement / stabilisierende Bindung an Interessen, Talente, Perspektiven, Lebensziele F2: Stabile innere Zeitlinie, historisch-biografisches Selbst, subjektive „self-sameness“ F3: Stabilisierende moralische Richtschnur	Sub 2.1 **Konsistentes Selbstbild** vs. Gegensätzlichkeit F1: Gleiche Eigenschaften bei unterschiedlichen Personen / Situationen F2: Keine extremen unüberbrückbaren inneren Gegensätzlichkeit F3: Gefühlte definierte Mitte und Substanz	**Selbst-bezogen** Intrapersonal Ebene: Ich und Ich
Sub 1.2 **Stabilität in Beziehungen** und Rollen vs. Fehlende Zugehörigkeit F1: Engagement / stabilisierende Bindung an dauerhafte Beziehungen F2: Positive Identifikation mit stabilisierenden Rollen (sexuell, ethnisch, kulturell, familiär) F3: Positives Körper-Selbst	Sub 2.2 **Autonomie**, Ich-Durchsetzung vs. Überidentifikation und Beeinflussbarkeit F1: Ich-Stärke, Durchsetzungsfähigkeit, keine Überidentifikation F2: Unabhängiger Selbstwert, Eigenständigkeit F3: Positive Affektregulierung	**Sozial-bezogen** Interpersonal Ebene: Ich und Du
Sub 1.3 **Emotionale Selbstreflektion** vs. Misstrauen in Stabilität von Gefühlen F1: Verstehen eigener Gefühle, innere Kommunikation, gute emotionale Zugänglichkeit F2: Verstehen fremder Gefühle, Vertrauen in Stabilität von positiven Gefühlen	Sub 2.3 **Kognitive Selbstreflektion** vs. Oberflächliche, diffuse Repräsentationen F1: Verstehen eigener Motive und Taten, gute kognitive Zugänglichkeit F2: Differenzierte und kohärente mentale Repräsentationen von sich und anderen	**Mentale Repräsentationen** Zugänglichkeit und Differenziertheit von eigenen und fremden Gefühlen / Motiven

Gemäss der dimensionalen Konzeption des AIDA sprechen hohe Ausprägungen in den Skalen Diskontinuität und Inkohärenz für das Vorliegen einer Identitätsdiffusion. Die inhaltlichen Facetten sind nicht als eigenständige Skalen gedacht, sondern dienen der Konstrukt-operationalisierung. Die internationale Arbeitsgruppe formulierte für eine Pilotversion in einem kooperativen Prozess Items mit einer fünfstufigen Likert-Skala, welche dann im Rahmen einer finalen Itemselektion nach statistischen Kriterien von 96 auf 58 Items reduziert wurden (für eine weiterführende Darstellung der Skalenkonstruktion siehe Goth et al., 2012a). In einer von der Ethikkommission beider Basel und dem hessischen Kultusministerium bewilligten Validierungsstudie (Goth et al., 2012a) wurde der AIDA-Fragebogen an einer gemischten Schulstichprobe aus Giessen mit N = 305 Schülern (148 Jungen, 157 Mädchen) zwischen 12-18 Jahren (AM 15.00, SD 2.01) und einer klinischen Stichprobe von insgesamt 52 Patienten (17 Jungen, 35 Mädchen; N = 20 mit Persönlichkeitsstörung) zwischen 12-18 Jahren (AM 15.58, SD 1.83) der KJPK Basel und einer Frankfurter Praxis für Kinder- und Jugendpsychiatrie validiert. Das Testset umfasste die beiden Fragbogen AIDA und „Junior Temperament und Charakter Inventar“ (JTCI 12-18 R; Goth & Schmeck, 2009) sowie für die klinische Teilstichprobe die beiden klinischen Interviews „Diagnostisches Interview bei psychischen Störungen im Kindes- und Jugendalter“ (K-DIPS; Schneider et al., 2009) und SKID-II (Fydrich et al., 1997). Die Ergebnisse zeigten sehr gute Skalen- (Diskontinuität: α = .86; Inkohärenz: α = .92) und Subskalenreliabilitäten (α = .73 -.86). Die Interkorrelationen zwischen den AIDA-Skalen und den Skalen des JTCI 12-18 R sprachen für eine hohe Konstruktvalidität. Die Kriteriumsvalidität wurde durch den Vergleich der Schulstichprobe und den Patienten mit einer nach SKID-II diagnostizierten Persönlichkeitsstörung beurteilt. Alle Skalen und Subskalen trennten beachtenswert zwischen den Gruppen mit Effektstärken von 1.04 bis 2.56 Standardabweichungen, was für eine hohe diagnostische Nützlichkeit des AIDA-Fragebogens im klinischen Alltag spricht (vgl. Tabelle 2).

Tabelle 2: Unterschiede in den Mittelwerten und die zugehörige Effektstärke d zwischen Schulstichprobe „schule“ und klinischer Substichprobe mit Persönlichkeitsstörungen „klinik-PD“ (aus Goth et al., 2012b, S. 9)

	AM (SD) n=305 **schule**	AM (SD) n=20 **klinik-PD**	Signifikanz p / Effektstärke d
Gesamtskala **Identitäts-Diffusion**	**65.87 (26.26)**	**129.75 (32.57)**	p = .000 / d = **2.17**
1. Diskontinuität	**27.72 (11.49)**	**56.20 (14.74)**	p = .000 / d = **2.17**
1.1 Eigenschaften	12.95 (5.29)	20.75 (7.16)	p = .000 / d = **1.25**
1.2 Beziehungen	6.48 (4.78)	19.65 (6.82)	p = .000 / d = **2.27**
1.3 emotion. Selbst.-refl.	8.30 (4.57)	15.80 (5.95)	p = .000 / d = **1.43**
2. Inkohärenz	**38.15 (16.85)**	**73.55 (19.65)**	p = .000 / d = **1.94**
2.1 Konsistentes Selbst	12.65 (7.09)	30.95 (7.20)	p = .000 / d = **2.56**
2.2 Autonomie	15.21 (7.37)	24.30 (10.04)	p = .000 / d = **1.04**
2.3 kogn. Selbst-refl.	10.29 (5.14)	18.30 (6.82)	p = .000 / d = **1.34**

Eine weitere Studie (Jung et al., 2013) untersuchte, aufbauend auf diesen Resultaten, die Identitätsentwicklung von Patienten mit unterschiedlichen Diagnosen. Hierfür wurden 86 Patienten (30 männlich, 56 weiblich) zwischen 12-18 Jahren (AM 15.24, SD 1.77) im Rahmen einer Fallkonferenz und unter Einbezug der beiden klinischen Interviews K-DIPS und SKID-II in eine der drei Diagnosegruppen „Internalisierende Störung“ (N = 22), „Externalisierende Störung“ (N = 10) und „Persönlichkeitsstörung“ (N = 24) zugeordnet. Es wurde auf die Erstellung von homogenen Diagnosegruppen geachtet, um Unterschiede in der Identitätsentwicklung resp. im Ausmass der Identitätsdiffusion eindeutig interpretieren zu können. 30 Patienten konnten aufgrund von Komorbidität oder anderen Diagnosen (bspw. Autismus) nicht eindeutig kategorisiert werden.

Varianzanalytisch bestätigte sich die Hypothese, dass Patienten mit einer Persönlichkeitsstörung („PD“) die höchsten Werte in allen AIDA-Skalen erreichen (∅ T = 73). Patienten mit einer externalisierenden Störung („external“) erreichten die niedrigsten Werte (∅ T = 49) und Patienten mit einer internalisierenden Störung („internal“) lagen mit ihren Werten (∅ T= 61) zwischen denen der beiden anderen Diagnosegruppen (vgl. Abbildung 1).

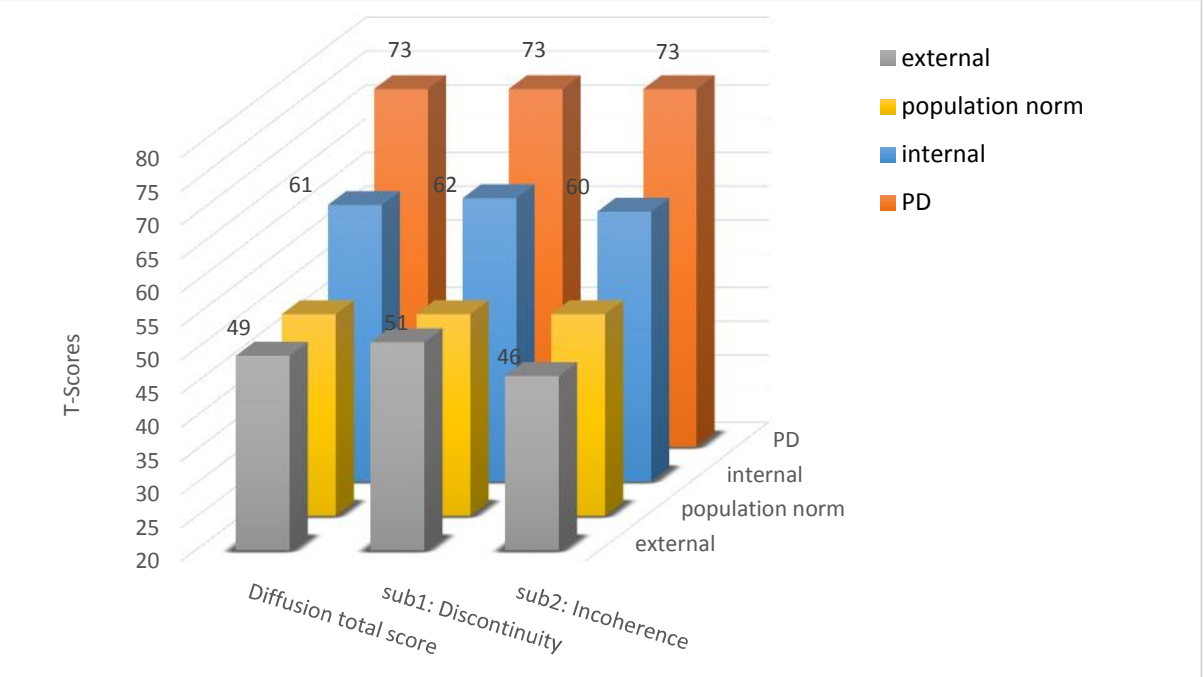

Abbildung 1: Vergleich der T-Werte in der übergeordneten AIDA-Skala “Diffusion total score” und den beiden Hautpskalen „Discontinuity“ und „Incoherence“ zwischen den verschiedenen Diagnosegruppen („external“, „internal“ und „PD“) und der Normpopoulation (T=50; aus Jung et al., 2013, S. 6)

Für die übergeordnete AIDA-Skala „Identitäts-Integration vs. Identitäts-Diffusion“ („Diffusion total score“) war die Effektstärke der Gruppendifferenzen mit f = 0.44 stark ausgeprägt.

Die Ergebnisse zeigen, dass mithilfe des AIDA zwischen Patienten mit unterschiedlichen Diagnosen unterschieden werden kann und dass Identitätsdiffusion, wie sie im AIDA konzeptualisiert wird, ein spezifisches Merkmal von Patienten mit einer Persönlichkeitsstörung ist und nicht bloss Ausdruck allgemeiner Psychopathologie. Das Ziel, zwischen Identitätskrise und -diffusion unterscheiden zu können, war in dieser Studie auf Subskalenebene nur bedingt erreichbar (vgl. Jung et al., 2013). Weitere Forschung mit einer grösseren Stichprobe und homogeneren Gruppen ist erforderlich, um AIDA-Werte profilbezogen auswerten zu können. Der AIDA wurde bisher in mehrere Sprachen übersetzt (vgl. Schmeck et al., 2013b) und bei anderen Altersgruppen („AIDA 19+“), Störungsbildern und Kulturen eingesetzt (bspw. Delinquente Jugendliche in Mexiko, Kassin et al., 2013; Jugendliche mit Abhängigkeitserkrankungen in Chile, Borzutzky et al., 2014).

4. Behandlung mit AIT

AIT ist eine Therapiemethode, welche auf die Behandlung der Identitätsdiffusion als ein zentrales Merkmal der Persönlichkeitsstörungen fokussiert. Ziel ist der Abbau von Entwicklungsblockaden und die Förderung der Identitätsintegration im Jugendalter, was einhergehend mit einer Stärkung von intra- und interpersonellen Funktionsbereichen wie Selbstregulation und Beziehungsgestaltung die Klärung von Lebenszielen ermöglicht. Um dies zu erreichen, baut AIT auf bindungs- und objektbeziehungstheoretische sowie neurobiologische und identitätsbezogene Konzeptionen auf und verbindet Vorgehensweisen der übertragungsfokussierten Psychotherapie mit verhaltenstherapeutischen und systemischen Therapieelementen zu einem integrativen Behandlungskonzept (Foelsch et al., 2013). Übertragungsfokussierte Therapieüberlegungen sind leitend in der einzeltherapeutischen Behandlungsplanung mit therapiestrategischer und -taktischer Ausrichtung sowie der Arbeit mit Übertragung und Gegenübertragung. Verhaltenstherapeutische und systemische Therapieelemente finden sich wieder in den direkten Interventionen im Umfeld des Patienten mit Psychoedukation, Familienarbeit und Erstellung eines „Homeplan“ (siehe Kapitel 4.1). AIT wird getragen von einer therapeutischen Haltung, die sich durch Offenheit, Optimismus, Neugier und Präsenz seitens des Therapeuten auszeichnet. Das Behandlungssetting beinhaltet ein bis zwei einzeltherapeutische Gespräche pro Woche mit begleitenden Eltern- und Familiengesprächen. Um eine positive Veränderung bei jugendlichen Patienten mit einer Identitätsdiffusion zu bewirken, braucht es eine AIT-Behandlungsdauer von mindestens sechs Monaten bis über einem Jahr. Es gibt einen dualen Behandlungsfokus mit einer fokalen Klärung akuter Probleme wie etwa

selbstschädigende Verhaltensweisen und einer längerfristigen auf die Identitätsdiffusion bezogene Klärung der diffusen Selbst- und Objektrepräsentanzen. Dem therapeutischen Prozess gehen eine ausführliche Diagnostik (u.a. mittels AIDA, siehe Kapitel 3), Indikationsstellung und Vertragsphase voraus.

4.1 Vertragsphase

Die Vertragsphase ermöglicht die Etablierung eines klaren Behandlungsrahmens mit der Definition der jeweiligen Verantwortungsbereiche des Jugendlichen, der Eltern und des Therapeuten in Bezug auf die vereinbarten Behandlungsziele wie regelmässiger Schulbesuch, Anwenden von adäquaten Konfliktlösungsstrategien, Selbstfürsorgeverhalten in emotional belastenden Situationen resp. Reduktion von selbstschädigenden Verhaltensweisen. Es wird zwischen einem individuellen und einem Familienvertrag unterschieden. Ersterer beinhaltet direkte Vereinbarungen zwischen dem Jugendlichen und dem Therapeuten wie die beidseitige Verpflichtung, regelmässig zu Therapieterminen zu erscheinen. Der Familienvertrag zielt auf die Unterstützung der Eltern, welche dem Jugendlichen helfen sollen, den individuellen Vertrag einzuhalten. Der „Homeplan“ ist eine Synthese dieser beiden Verträge und dient in seiner schriftlichen Form als Hilfs-Ich, um die Selbstreflektion aller am therapeutischen Prozess Beteiligten zu stärken. Er definiert Konsequenzen für bestimmte Verhaltensweisen, bietet bei intrafamiliären Konflikten Orientierung und macht Krisen erklär- und bewältigbar (Schlüter-Müller et al., in press).

4.2 Taktiken und Techniken in der Behandlung mit AIT

Nach erfolgter Auftragsklärung und Vertragsabschluss beginnt die therapeutische Arbeit, in der sich der Therapeut an Taktiken orientiert, die dem übergeordneten Therapieziel, eine Integration abgespaltener Objektbeziehungsdyaden und eine damit verbundene Auflösung der Identitätsdiffusion beim Patienten zu erreichen, dienen. Gemäss Foelsch und Mitarbeiter (2013) sind folgende vier Taktikten in der Behandlung bedeutsam:

1. Bewahren des vereinbarten Behandlungsrahmens mit Restitution nach Vertragsbruch
2. Erkennen des dominanten Affekts
3. Regulation von intensiven Affekten
4. Priorisierung von Interventionen (Selbst- und Fremdgefährdung vor anderen Brüchen des Therapievertrages und vor der Arbeit an der Identitätsintegration)

Die drei Behandlungstechniken Klärung, Konfrontation und Deutung ermöglichen einen interpretativen Prozess hinsichtlich der inneren Objektbeziehungswelt und bauen auf einer aufmerksamen Wahrnehmung der drei Kommunikationskanäle zwischen dem Therapeuten und dem Patienten auf, welche aus verbaler Kommunikation, nonverbaler Kommunikation und Gegenübertragung bestehen (Clarkin et al., 2008).

Bei der Klärung fordert der Therapeut den Jugendlichen auf, für ihn unklare und widersprüchliche Gesprächsinhalte (erneut) zu erklären. Ziel ist es, die Bedeutung von Gefühlen und Handlungen zu verstehen und die Mentalisierungsfähigkeit des Jugendlichen zu stärken. Bei der Konfrontation zielt der Therapeut auf die Bewusstmachung von im Klärungsprozess aufgetauchten Widersprüchen. Dabei werden Inkongruenzen in den Kommunikationskanälen dem Jugendlichen als Einladungen zur Selbstreflektion wertschätzend und hypothesengeleitet angeboten, z.B.: „Wie können wir uns gemeinsam erklären, dass Du wiederholt lächelst, während Du mir von diesen belastenden Erfahrungen berichtest?“ Klärung und Konfrontation bereiten oft eine Deutung vor, welche Informationen verbindet und als Hypothese formuliert dem Jugendlichen eine Erklärung für Widersprüche anbietet. Im Anschluss an eine Deutung folgt häufig wiederum ein zyklischer Prozess aus Klärung und Konfrontation (Foelsch et al., 2013).

AIT unterscheidet sich von der übertragungsfokussierten Therapie mit Erwachsenen (TFP) in der Betonung einer grösseren Klärungsarbeit, dem Einbezug der Familie und der primären Interpretation von Beziehungsmustern ausserhalb der Therapie mit Peers und Familienangehörigen, bevor auf Übertragungsinteraktionen im Hier und Jetzt der therapeutischen Situation eingegangen wird (Foelsch et al., 2008).

4.3 Studien zur Wirksamkeit von AIT

Für die übertragungsfokussierte Therapie für Erwachsene (Clarkin et al., 2008), von der in der AIT wesentliche Therapieelemente für das Jugendalter adaptiert wurden, konnte in vier voneinander unabhängigen Studien die Wirksamkeit überzeugend dargelegt werden (Clarkin et al., 2001; Clarkin et al., 2007; Giesen-Bloo et al., 2006; Döring et al., 2010). Eine nichtrandomisierte Vorstudie mit 23 jugendlichen Patienten mit einer diagnostizierten Borderline-Persönlichkeitsstörung zeigte einen insgesamt vergleichbaren Behandlungserfolg zwischen AIT und einer Standardbehandlung (TAU) mit einer signifikant stärkeren Verbesserung im allgemeinen Funktionsniveau und einer stärkeren Symptomreduktion in der AIT- als in der TAU-Gruppe (vgl. Foelsch et al., 2013).

Eine weiterführende, multizentrische Therapiestudie mit einer grösseren Stichprobe ist unter Mitarbeit des Referenten in Vorbereitung. Geplant ist ein Vergleich zwischen AIT und DBT-A mit einem Fokus auf Prozessforschung unter Einbezug von audiovisuellem Material und physiologischen Messdaten.

5. Schlussfolgerungen

Die Forschung der letzten 20 Jahre zeigt, dass Identitäts- und Persönlichkeitsstörungen bedeutende Formen der Psychopathologie im Jugendalter sind (Chanen et al., 2007; Westen et al., 2005), welche reliabel und valide diagnostiziert werden können (Levy et al., 1999; Westen 2003, vgl. Jung et al., 2013). Da die klassisch kategoriale Diagnostik erhebliche Probleme aufweist, schlägt das alternative DSM-5-Modell einen begrüssenswerten Fokuswechsel hin zu einer zusätzlichen Orientierung an basalen Beeinträchtigung von intra- und interpersonellen Persönlichkeitsfunktionen vor und trägt der Bedeutung der Identitätsstörung als einem Kernmerkmal von Persönlichkeitspathologie explizit Rechnung. Dies ist sinnvoll, da die reine Symptomreduktion nicht zwangsläufig mit einem verbesserten Funktionsniveau einhergeht, was in der Psychotherapie von Patienten mit einer Persönlichkeitsstörung oft der Fall ist. Vielmehr erreichen diese Patienten dann im Behandlungsverlauf die Anzahl der notwendigen Diagnosekriterien nicht mehr, grundlegende Beeinträchtigungen bleiben dennoch bestehen. Folglich sollten Behandlungserfolge nicht alleine durch eine Symptomremission sondern auch anhand des Entfaltungsgrades von persönlichkeitsbezogenen Fähigkeiten und Funktionen wie Selbststeuerung, Identitätsintegration, Empathie- und Beziehungsfähigkeit definiert werden, welche den Patienten längerfristig eine gelingende Lebensführung mit einer Zunahme an Lebensqualität ermöglichen (Feenstra et al., 2014). Es gibt Hinweise, dass Veränderungen dieser Persönlichkeitsfunktionen eindeutig mit positiven Behandlungsergebnissen im Sinne einer Symptomreduktion einhergehen (Levy et al., 2006; Rossouw & Fonagy, 2012). Entsprechend kann auch die Zunahme an Identitätsintegration als ein sensitives Mass in der Behandlung von adoleszenten Patienten mit einer Persönlichkeitsstörung gesehen werden (Feenstra et al., 2014).

Der AIDA-Fragebogen ist ein wertvolles Diagnoseinstrument, um das Niveau an Identitätsintegration resp. -diffusion bei Jugendlichen zu erfassen. AIT ist eine vielversprechende Therapiemethode, welche auf die Behandlung von Jugendlichen mit einer Identitätsdiffusion fokussiert und neben der Symptomreduktion auch auf die wichtigen Veränderungen in den basalen Persönlichkeitsfunktionen zielt, um längerfristig eine gesunde Entwicklung zu

ermöglichen. Sowohl AIDA als auch AIT greifen die aktuellen internationalen Entwicklungen in der veränderten Diagnostik und Therapie von jugendlichen Patienten mit einer Persönlichkeitsstörung auf und führen sie weiter. Weiterführende Studien sind erforderlich und geplant, um die Grenzen und Möglichkeiten von AIDA und AIT aufzuzeigen.

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7. Anhang

CHILD & ADOLESCENT
PSYCHIATRY & MENTAL HEALTH

RESEARCH Open Access

Assessment of identity development and identity diffusion in adolescence - Theoretical basis and psychometric properties of the self-report questionnaire *AIDA*

Kirstin Goth[1*], Pamela Foelsch[2], Susanne Schlüter-Müller[3], Marc Birkhölzer[4], Emanuel Jung[1], Oliver Pick[1] and Klaus Schmeck[1]

Abstract

Background: In the continuing revision of Diagnostic and Statistical Manual (*DSM-V*) "identity" is integrated as a central diagnostic criterion for personality disorders (self-related personality functioning). According to Kernberg, identity diffusion is one of the core elements of borderline personality organization. As there is no elaborated self-rating inventory to assess identity development in healthy and disturbed adolescents, we developed the *AIDA* (Assessment of Identity Development in Adolescence) questionnaire to assess this complex dimension, varying from "Identity Integration" to "Identity Diffusion", in a broad and substructured way and evaluated its psychometric properties in a mixed school and clinical sample.

Methods: Test construction was deductive, referring to psychodynamic as well as social-cognitive theories, and led to a special item pool, with consideration for clarity and ease of comprehension. Participants were 305 students aged 12–18 attending a public school and 52 adolescent psychiatric inpatients and outpatients with diagnoses of personality disorders (N = 20) or other mental disorders (N = 32). Convergent validity was evaluated by covariations with personality development (*JTCI 12–18 R* scales), criterion validity by differences in identity development (*AIDA* scales) between patients and controls.

Results: *AIDA* showed excellent total score (Diffusion: α = .94), scale (Discontinuity: α = .86; Incoherence: α = .92) and subscale (α = .73-.86) reliabilities. High levels of Discontinuity and Incoherence were associated with low levels in Self Directedness, an indicator of maladaptive personality functioning. Both *AIDA* scales were significantly different between PD-patients and controls with remarkable effect sizes (d) of 2.17 and 1.94 standard deviations.

Conclusion: *AIDA* is a reliable and valid instrument to assess normal and disturbed identity in adolescents. Studies for further validation and for obtaining population norms are in progress and may provide insight in the relevant aspects of identity development in differentiating specific psychopathology and therapeutic focus and outcome.

Keywords: Identity, Questionnaire, Overview, Psychometrics, Personality disorder, Adolescence

* Correspondence: kirstin.goth@upkbs.ch
[1]Child and Adolescent Psychiatric Hospital, Psychiatric University Hospitals Basel, Basel, Switzerland
Full list of author information is available at the end of the article

Background

Identity and its disturbance are viewed as central constructs in psychoanalytic and psychodynamic theories, finding its counterparts in the area of social-cognitive theories using terms such as basic "self-concepts" and "mental representations". In general terms, identity could be defined as „unity of being" but the attempt to find a comprehensive definition immediately shows its hybrid nature, being both intrapsychic and interpersonal, and its various phenomenological aspects complicating an operationalization along its true constituents [1].

In the following, we will discuss first concepts of healthy identity development and then concepts of disturbed identity, both times addressing psychodynamic as well as social-cognitive and empirical approaches. With this background, we will motivate the concrete scale development in contrast to perceived shortcomings of existing approaches.

Erikson described identity as a fundamental organizing principal, developing constantly throughout life and providing a sense of continuity within the self and in interaction with others („self-sameness") as well as a frame to differentiate between self and others („uniqueness"), which allows the individual to function autonomously from others [2]. He described the consolidation of identity as a central task in normal adolescent development, when previous identifications and introjections had to be shed and transformed in a process that is called an identity crisis. In the operationalized psychodynamic diagnostic inventory (*OPD-2)*, normal identity is described as „... the entirety of the inner pictures of oneself", closely related to the "ideal self". In its development "special phases lead to conflicts that may result in a subjective feeling of continuity and coherence, when integration of new self-images into identity succeeds." [3]. As a result, a stable identity plays a role in self-esteem, a realistic appraisal of self and others, and insight into the effect one has on another [4]. Therefore, identity aids in self-reflective functioning, autonomy, effective social exchanges and provides predictability and continuity of functioning within a person, across situations, and across time [5].

A distinction between two different aspects of identity can be found in many theories from social-cognitive and developmental psychology [6,7]. James (1890 in [6]) made the classical distinction between the "I", an intuitive, emotionally experienced vital self-evidence, and the "ME", a result of a self-reflective process leading to an integrated awareness and knowledge about oneself. Thus, identity can be divided into the two higher order domains "subjective self" (focussing on continuity, "stable core", emotional access) and "definitory self" (focussing on coherence, "integrated whole", cognitive access). In contrast, Stern (1985 in [6]) postulated four components of self: "self-agency" (sense of authorship) and "self-coherence" (sense of non-fragmented, physical whole with boundaries) as well as "self-affectivity" (experiencing inner qualities of feeling) and "self-history" („going on being", the possibility to change while remaining the same). Different authors introduced different sets of single self-concepts to fully describe a person's "identity system". Bracken [8] articulated six self-concepts which refer to different areas of psychosocial functioning: Social, Competence, Affect, Academic, Family, and Physical. Deusinger [9] describes ten self-concepts reflecting: efficiency, problem solving, certainty in behavior- and decision making, self worth regulation, sensibility and moodedness, persistence, social ability, appreciation from others / role security, confusability, emotions and relationships. Referring to Erikson's concept of ego growth, strength and synthesis [10], Marcia [11,12] differentiates between the four statuses of identity formation: Diffusion, Foreclosure, Moratorium and Achievement. Each formation is defined by a specific combination of high vs. low "commitment" and "exploration", regarded as the central areas for defining identity. Associated approaches strengthen the necessity of a cognitive elaboration of commitments to constitute identity achievement, which is linked to a healthy development [13,14].

Fonagy et al. [15] combined psychoanalytic concepts with attachment theory and „theory of mind" to a joint concept of „mentalization", describing the development of complex mental representations of self and others based on the development of emotion regulation (self-control, affect-control), the capacity for intersubjectivity (imitation, role-acceptance, change of perspective), and reflective self-functions. These mental representations evolve progressively as a result of self-reflection and facilitate the understanding, prediction, and consideration of ones own and others' mental states. This can be viewed as a basic requirement for the formation of an experience of identity. Additionally, Seiffge-Krenke [16] emphasizes the significant changes in adolescence, not only by the need to develop entirely new self-images and roles (e.g. as a sexual partner), but also by the age-related cognitive changes from concrete to formal operational patterns (abstract) of thinking and by the need to "debond" from the parents. This creates feelings of loneliness, sadness, anger and emotional detachment and an "erosion" of the former stabilizing child's identity.

According to Otto Kernberg, identity crisis results from the discrepancy between rapidly shifting physical and psychological experiences, on the one hand, and a widening gap between self-perception and the experiences of others' perceptions of the self, on the other hand [17]. In identity crisis, continuity of self remains across situations and across time despite experimentations with

different roles and usually resolves into a normal, consolidated identity with flexible and adaptive functioning [5]. This permits the adolescent or young adult to develop rewarding and satisfying friendships, to form clear life goals, to interact appropriately with parents and teachers, to establish sexual and intimate relations, and to develop positive self-esteem [18].

In contrast, identity diffusion is viewed as a lack of integration of the concept of self and significant others. This results in a loss of capacity for self-definition and commitment to values, goals, or relationships, and a painful sense of incoherence. This is often observed as "unreflective, chaotic and contradictory descriptions of the patient about himself and others" and the "inability to integrate or even perceive contradictions" [19,20]. According to Kernberg, an incompletely integrated identity may additionally manifest in either chronic emptiness, contrary behavior and superficiality or in other signs of weak ego-strength like poor anxiety tolerance and impulse control. Identity development can be described as a continuum with an identity diffusion (incoherent self-image, self-fragmentation) at one end and an integrated personal identity at the other end [21]. Overall, identity diffusion is a core element of the "borderline personality organization" [21] and is viewed as the basis for subsequent personality pathology, leading to a broad spectrum of maladaptive and dysfunctional behaviors [14].

Other authors focus on borderline personality disorder (BPD) in their studies, since this patient group characterizes significant personality pathology particularly in the disturbance of identity. Westen described "identity disturbance" as the central construct for detecting severe personality pathology, and most notably BPD, in adults and adolescents, containing the dimensions: lack of commitment, role absorption, painful incoherence and lack of consistency, assessed with an expert rated questionnaire *IDQ* [22]; Crick developed a questionnaire (*BPFS-C)* to assess borderline personality features in children, based on Morey's concept for adults, which integrates "identity problems" in addition to the factors affective instability, negative relationships and self-harm [23]. Poreh established a *DSM-IV* criteria based questionnaire (*BPQ)* to assess borderline personality in adults with nine subscales: Impulsiveness, Affective Instability, Abandonment, Relationship, Self-Image, Suicide/Self-Mutilation, Emptiness, Intense Anger, and Quasi-Psychotic States, all contributing empirically to a joint borderline factor called "Identity/Interpersonal" [24,25]. In the *DSM-IV* [26] identity disturbance (i.e. "markedly and persistently unstable self-image or sense of self," p. 654) is included as one of the components of borderline personality disorder. This was supported empirically by many findings, including Becker [27] who found identity disturbance and affective dysregulation in adolescents to be the most significant symptoms in leading to a correct diagnosis of borderline personality disorder.

The lack of empirical support for the categorical method of diagnosing personality disorders, diagnostic thresholds and the heterogeneity of PD diagnoses [28,29], led to a complete revision [30] of PD diagnoses for the new *DSM-V* (http://www.dsm5.org). From 2013 on, a hybrid model including dimensions and categories shall be used. At present, six specific personality disorder types (antisocial, schizotypal, borderline, narcissistic, obsessive-compulsive, avoidant) should be evaluated according to a set of criteria based on core impairments in personality functioning and pathological personality traits from two different domains: self functioning (dysfunctionality) and interpersonal (social maladaptivity). Impairments in self functioning are reflected in dimensions of identity and self-direction. Interpersonal impairments consist of impairments in the capacities for empathy and intimacy. With this, the concept of identity per se and Kernberg's concept of identity diffusion is assigned to play a central role in defining and detecting personality disorders on a general level, not only as a specific trait in borderline PD. As inventories and interviews for assessing the new criteria are under construction internationally, also identity has to be modeled in a highly structured and elaborated way.

Early signs of personality disorders, with considerable stability despite developmental stage [31-33], are apparent before the age of 18 [34,35]. Therefore, deviations from normal personality development in children and adolescents can and should be identified and targeted for intervention [5,22,36,37]. As adolescent identity diffusion can be described consistently with Otto Kernberg's conceptualization of adult identity diffusion [38,39], the treatment designed for adults with identity diffusion *TFP* (Transference Focused Psychotherapy) [40] should be effective in adolescents with identity diffusion as well, provided that developmentally appropriate modifications are implemented. Paulina Kernberg elucidated in 2000 a model for understanding identity pathology in children and adolescents and postulated that identity diffusion is the result of failure to consolidate identity at each stage from childhood through adolescence [5]. Her emphasis in adolescence was on the need to differentiate those with normal identity crisis from those with identity diffusion and to intervene directly during this developmental period. In this sense, and in continuing the work of Paulina Kernberg, the psychotherapeutic approach *TFP-A* (Transference Focused Psychotherapy - Adolescent Identity Treatment, AIT) [4,41] was developed to treat adolescents with identity diffusion in order to help them to improve identity integration and hence increase adaptive functioning

and behavior by improving their relationships with friends, parents, and teachers, acquiring positive self-esteem, clarifying life goals and be better prepared for entering love relationships [18,42].

Based on the concepts described above, our Swiss-German-American research group started in 2010 to develop the questionnaire *AIDA* (Assessment of Identity Development in Adolescence) to measure identity development in adolescents. *AIDA* is designed to overcome psychometric shortcomings of the questionnaire *IPO-CH* [43], an adaption of the *IPO* [44] ("Inventory for Personality Organization") for children and adolescents. For example, the heterogeneity of the scales and the ambiguity and confounds with non-target constructs like trait-impulsivity on the item level [45]. The construct "identity" has been given the priority over other disturbance-related aspects like object relations, primitive defences, moral values, aggression or reality testing. These have been integrated relative to their relation to identity diffusion. Following this approach, the development of an adapted version for adolescents of the interview *STIPO* [46] is currently in progress by an Italian research-group.

Scale construction for *AIDA*

Our initial goal was to assess identity development on a well-founded Likert scale ranging from "healthy" to "disturbed" in order to differentiate healthy identity development from a current identity crisis as well as from a severe identity diffusion. This was part of our research about the prevalence and specific development of personality disorders in adolescence. But our review of literature yielded that the existing approaches were either too much focused on pathology and did not assess normal variants of identity development adequately or they focused on healthy development and disregard a structured integration of disturbed personality. The former were mostly formulated in interview form [46] or as an expert rating [22], symptom-oriented in content and, even as a self- rating questionnaire [47], usually targeting adults. The latter are predominantly developed as self-rating questionnaires, similar to personality inventories, and designed to capture general self concepts without specifying an elaborated link to pathology [8,9,48,49], even in Akhtar & Samuel's *ICI* to assess explicitly "components of identity" [50]. So we decided to develop a new questionnaire based on a broad description of the field, using a deductive test construction, in which the structure of a targeted construct is carefully elaborated with respect to underlying factors concerning causation, psychological, or social functions [51,52], and following strict modeling techniques concerning the internal structure of higher order scales, subscales and facets with precise definitions within (truly shared content) and differentiations between them (no shared content or trivial item-overlap) [53,54] to maximize construct validity. For conceptual clarification and a broad capturing of normal as well as disturbed development of identity, the scale construction process for *AIDA* integrated the concordant approaches from psychoanalytic and social-cognitive psychology (see above) and, additionally, the constructs, subconstructs, and items modeled by existing inventories for assessing identity had been analyzed carefully and integrated in a re-assembled way. In this process, we kept the originally used names for the subconstructs as far as possible to facilitate traceability and clarity of the content.

From the abovementioned theoretical descriptions about identity development, two domains could clearly be distinguished in line with the constructs´ dichotomy in social-cognitive psychology as well as in the psychopathology-oriented psychodynamic descriptions: a basic distinction between "Continuity" and "Coherence", serving as a well elaborated theoretical framework to find a meaningful and distinct substructure of the higher order construct "identity integration vs. identity diffusion".

- The construct "Continuity" represents the vital experience of "I" and subjective emotional self-sameness with an inner stable time line. High "Continuity" is associated with the stability of identity-giving goals, talents, commitments, roles, and relationships, and a good and stable access to emotions as well as the trust in the stability of them. A lack of Continuity (i.e. high "Discontinuity") is associated with a missing self-related perspective, no feeling of belonging and affiliation, and a lack of access to emotional levels of reality and trust in the durability of positive emotions.
- The construct "Coherence" stands for clarity of self-definition as a result of self-reflective awareness and elaboration of the "ME", accompanied by consistency in self images, autonomy and Ego-strength, and differentiated mental representations. A lack of Coherence (i.e. high "Incoherence") is associated with being contradictory or ambivalent, suggestible and over-matching, and having poor access to cognitions and motives, accompanied by superficial and diffuse mental representations.

Within these two domains, we additionally subdivided each into three different sub-domains, each reflecting the different areas of psychosocial functioning: self-related, social-related, and ability/reflection-related (see Figure 1). This enabled the reassemblance of the known identity-related subconstructs into a meaningful joint framework, providing a maximum of source-related compilation of the contents based on the theoretical

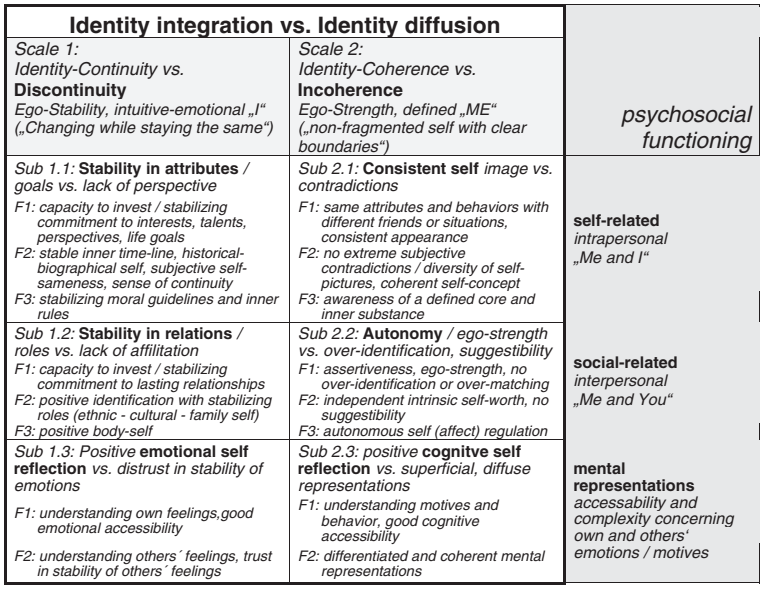

Figure 1 Theory-based suggestion for a meaningful substructure of the construct "Identity Integration vs Identity Diffusion" and its operationalization into *AIDA* scales, subscales, and facets.

descriptions. With this, we are uniting the "hybrid nature" of the construct (being both intrapsychic and interpersonal, [1]), the studies related to developmental identity formation (distinct aspects commitment and exploration) [12], and concepts of identity-related reflective functioning and mental representations according to Fonagy [15,47] in an elaborated way. To a great extent, we could integrate the central operationalizations of identity diffusion (ID) by O. Kernberg (capacity to invest, continuity over time, representation of others, superficiality, loneliness, self-coherent opinions and self esteem) [21] and Westen (lack of commitment, role absorption, over-identification, painful ambivalence, inconsistency) [22] into the described higher-order structure. Compared to the described "levels of personality functioning" for the *DSM-V*, all central aspects of identity are integrated in the *AIDA* structure as well.

The construction process of the concrete item formulations to integrate the referred subconstructs addressed a central shortcoming of some of the existing inventories: the lack of clarity concerning the targeted subconstructs (e.g. mixed contents) and/or the inappropriateness of the formulations for self-assessment in adolescents (e.g. too complicated).

The complexity of construct clarification in test operationalization is showing clearly within the aspect "identity related to relationships". On the one hand, the adoption of and identification with social roles, such as in the family, sexual roles, and cultural roles, is stabilizing identity in a very positive way, fully corresponding with Samuel and Akhtars´ components of identity and in our model assigned to the area Continuity. But, on the other hand, a too strong identification with roles and openness for social attention is seen as a sign of identity disturbance called e.g. role-absorption and over-identification in Westen's concept and described as not having own opinions, goals, and self-esteem, being defined by others, which is in our model clearly assigned to the area Coherence. The difference lies in the true integratedness of the adopted roles and if they really match with one's talents and perspectives or if they are just an artificial mask, the latter speaking for a lack of autonomy and assertiveness against social influences. It is obvious that this difference is highly significant and can not be assessed by asking the number of roles a person is identified with, as a lot of roles may indicate either a positive or negative sign concerning identity development. So we tried to keep out all mixed or unclear contents and targeted directly either "Continuity – stabilizing roles vs. lack of social roots" or "Coherence – autonomy vs. suggestibility" in our test construction.

Similarly, we tried to make clear the distinction concerning „identity disturbance in terms of being contrary – or being unstable – or experiencing painful ambivalence". In simple terms: it makes a tremendous difference concerning assumed identity integratedness if an

adolescent is switching hobbies and life goals because of (a) having an impulsive temperament or (b) having a lack of internal temporal continuity to himself, his social environment and his feelings (self-sameness) or (c) having different hobbies with every different peer group like a chameleon while the different self's are not connected on a higher level (self-coherence). To catch the truly targeted construct "identity" it is crucial to separate the distinct subconstructs regarding their clinical and psychological impact (e.g. "unsettled, not-persistent" vs. "chaotic, empty, two-faced"), even though it may look the same from the outside (phenotype "switching hobbies") and to leave out the non-target constructs in the scale and item construction process, especially "impulsivity". Trait impulsivity itself is not regarded as a risk factor to develop a personality disorder and may just be used to characterize the type, if a personality disorder should occur throughout life. Given this, it is crucial to keep out any impulsivity items to catch the phenomenon "identity" with reference to a disturbed development. Impulsivity, as a quasi-automatic emotional tendency to change interests and hobbies, to make quick decisions, to react before thinking, and to be prone to sensation seeking, can thus be seen as a perfect alternative hypothesis to what is described as "identity discontinuity" in terms of being unsure about own talents, own feelings, own affiliations. To summarize, being impulsive can be fun and lively and experienced as an active "I" whereas, having no inner continuity is not.

Altogether, the inventory *AIDA* is substructuring the higher order construct "Identity Diffusion" as constituted by the two separable scales "Disontinuity" and "Incoherence", each assessed as a sum of their three subscales reflecting distinct psychosocial functions. The facet level presented in Figure 1 is not supposed to be used independently (i.e. like sub-subscales) but is defined to facilitate conceptual clarity and to ease stringent scale and item construction. All scales are coded towards pathology, so high scores indicate high disturbance.

This current study examines the psychometric properties of the questionnaire *AIDA*. The sufficiency of homogeneity is tested by several item coefficients, scale reliabilities Cronbach's α, and phenotypical factorial structure in explorative factor analyses (EFA). The construct validity is examined by convergent and discriminant validities with related constructs, here with the personality dimensions according Cloninger's biopsychosocial model, and the construct validity, in terms of diagnostic validity, is evaluated directly by comparing the *AIDA* scores on scale and subscale level between psychiatric patients and healthy controls.

Cloninger's biopsychosocial model of personality claims to provide insight in the development of personality disorders as well as giving a theory-based and elaborated description of overall personality [55-58]. By dividing the two areas of personality "temperament" from "character" it combines person-centered aspects of general vulnerability and environment-centered aspects of dysfunctional influences and allows the evaluation of an individual's current maturity in terms of impaired personality functioning. Thus, Cloninger's model is ideally suited for investigating PD-related issues [59-62]. With the JTCI-R-family (Junior Temperament and Character Inventory) the concept can be assessed by questionnaire in adolescents (12–18 years) equivalent to the revised adult version *TCI R* with excellent results for reliabilities and validity [63,64]. With its two central diagnostic factors Self Directedness and Cooperativeness, Cloninger's concept of character perfectly covers the new *DSM-V* criteria concerning PD diagnoses. Especially the herein described impairment of intrapersonal personality functioning is supposed to be covered by the combination of Self Directedness (*JTCI 12–18 R)* and Identity Diffusion measured by *AIDA*.

Methods

Participants and Procedures

We assessed a clinic and a school sample to (a) gain a heterogeneous sample for test validation by mixing children and adolescents with typical development and those with assumed identity problems in order to cover the whole distribution of the targeted construct and avoid sample-specific ceiling or floor effects that potentially distort item-characteristics and to (b) provide data for analyzing the criterion validity and detailed relations to specific psychopathology of the *AIDA*-scores by comparing the results of patients and healthy controls. The study was approved by the Ethics Committee Basel / Switzerland (EKBB) as well as by the Ministry of Education Hessen / Germany.

Sample I consisted of 305 6–12 grade adolescent students (148 boys, 157 girls) from two public schools which were chosen as representative of the area. The mean age of the sample was 15.00 years (SD 2.01), age range was 12 to 18 years. Data collection took place at the schools in a group-setting by classes or grades during one school hour. Prior to the assessment the study was explained to the students and written consent from the parents, that had been handed out one week before, was collected as a requirement for participation. In a classroom setting, with an undergraduate research assistant available to answer questions, the students were asked to fill out the two questionnaires by themselves without talking. The total classroom participation rates ranged from 63% to 86% (MEAN = 74%).

Sample II involved a clinical sample of 52 adolescents (17 boys, 35 girls), with ages ranging from 12 to 18 years and a mean age of 15.58 years (SD = 1.83). Participants

were inpatients and outpatients of a child and adolescent psychiatric university hospital and a child and adolescent psychiatric practice. Inclusion criteria were age 12–18 years, sufficient linguistic and cognitive skills to master the written task and no current psychotic episode. The patients showed a variety of psychiatric problems, N = 20 with diagnoses of personality disorders (N = 18 type "emotional-unstable"), N = 12 with affective disorders (anxiety, depression), N = 7 with attention and conduct disorders and N = 13 showing high comorbidity. Diagnoses were based on clinical interviews (see below). Following the approved IRB protocol, therapists provided a complete description of the study to the participants and written informed consent was obtained from the adolescents and the parents. The two semi-structured interviews were conducted by a graduate psychological research assistant.

Measures

AIDA

AIDA was developed following systematic test construction procedures [65] with two stages. First stage was the theoretical explication of the targeted construct and the generation of a specific initial item pool by expert consensus. These items were pretested to ensure ease of comprehension and clarity of the items in the targeted age group. This served as the basis for further item modifications. Second stage was the empirical selection based only on the obtained statistical or psychometric properties of the items in the main sample to derive the final item pool and establish the targeted scales. Following this, all *AIDA* items were reviewed in detail between the authors, introducing different approaches and expertises, to obtain final consensus agreement. We focused on the items´ conceptual distinctness and each definite relation to pathological or healthy identity development as well as on their true potential to be answered correctly by adolescents concerning effects like social desirability, gender-related bias and conscious accessibility of the content (e.g. the statement "I admire people in order to feel secure" may be asked by an expert in an interview-situation, but would pose validity concerns in self-rating). The latter involves special considerations about age-related ability for self-reflection and/or the emotional discomfort, especially regarding sexual issues in a questionnaire-situation without having a relationship to the investigator. While the topic is clinically relevant, a component of identity and a phenotypical marker of the construct, it was omitted from the item pool due to the lack of reliability and validity in a self-report format. Thus, this important topic "concrete sexuality – gender-related satisfaction" will need to be evaluated by the therapist, as simply not every issue is applicable to this kind of operationalization.

The initial item pool with 102 items had been tested with 15 adolescents, leading to some modifications and a reduced pilot version with 96 items (e.g. leaving out the items about sexual development because of high missing rates or negative feedback of the adolescents). Items were rated on a 5-point Likert scale (0 = no, 1 = more no, 2 = part/part, 3 = more yes, 4 = yes). Additionally, six semi-open questions about own and best friends´ hobbies or interests (e.g. "What kind of hobbies or interests do you have, that describe you well?"), perceived group-affiliations, and typical attributes were asked to challenge the probands productivity and simulate an interview-like situation for creating a set of supportive variables in expert rating, using a fixed coding schema. These variables focus on contents that are difficult to catch with classical items, on the one hand covering the *AIDA* facets "superficiality vs. differentiated descriptions / representations" and "over-identification", on the other hand integrating two new subconstructs "self-stigmatizing" (following Westen [22]) and "compliance vs. defiant attitude". This *AIDA* pilot version had been tested with 47 adolescents aged 11–19 (MEAN 15.51, SD 2.39; 62 % girls), enriched with the first 22 patients (12 with PD diagnosis) of our clinical sample (age MEAN 15.86, SD 1.89; 64 % girls) and a preliminary testwise item-selection with this N = 69 sample supported a fully reliable reduced questionnaire with the suggested scale structure and reliabilities of $\alpha \geq .90$.

JTCI 12–18 R

JTCI 12–18 R [63] (Junior Temperament and Character Inventory - Revised) contains 103 statements in a five-step answer mode to assess personality development via four temperament scales ("Novelty Seeking / behavioral activation", "Harm Avoidance / behavioral inhibition", "Reward Dependence / social responsiveness", "Persistence / intrinsic motivation") and three character scales ("Self Directedness / individual functionality", "Cooperativeness / social adaptivity", "Self Transcendence / embeddedness") in self-rating according to Cloninger's biopsychosocial model and is appropriate for adolescents between 12–18 years (+/− 2 years). It is part of a test set constructed in German language in cooperation with Cloninger to reflect his revised operationalization for adults (*TCI R*) [66] on truly equivalent scales for children (*JTCI 3–6 R*, *JTCI 7–11 R)* and adolescents (*JTCI 12–18 R*, *JTCI 12–18 R Parent)* on scale and defined subscale level [67]. Psychometric properties for all these JTCI-R versions are very good [67,68], for the German *JTCI 12–18 R* the scale reliabilities α are between .79 and .85, excellent construct validity had been shown with CFA (temperament: CHI^2/df: $CHI^2/df = 1.96$, $RMSEA = .05$, $AGFI = .96$; character: CHI^2/df: $CHI^2/df = 0.43$, $RMSEA = .00$, $AGFI = .99$) [64] and promising results for diagnostic validity were

demonstrated by assumed covariations with severity (character scales) and type (temperament scales) of current psychopathology [67].

SCID-II and *K-DIPS*

As the aim was to explore the thresholds between healthy development, identity crisis and identity diffusion, valid and broad measures for psychopathology were needed. We used the two well-established semi-structured diagnostic interviews *SCID-II* [69] and *K-DIPS* [70]. *SCID-II* (The Structured Clinical Interview for *DSM-IV* Axis II) is designed to assess personality disorders according to *DSM-IV* criteria. Administration time is about 90 minutes. *K-DIPS* (Children – Diagnostic Interview for Psychiatric Diseases) is designed to assess axis I psychopathology in children and adolescents according to *ICD-10* and *DSM-IV* criteria, and takes about 90–120 minutes to administer.

Statistical analysis

The Statistical Package for the Social Sciences (SPSS 16 for Windows) was used for data analyses. Item analyses and selection was based on the criteria: percentage of symptomatic answers (5-95%), effect size *f* of gender- or age-related item bias $< .40$, mean item-total correlation $r_{it} > .30$, and potentially improving scale reliability Cronbach's α by item rejection while avoiding trivial redundancy as well as keeping a broad balance of scale content. Therefore, the item selection was carried out subscalewise. The mean r_{it} was built of the results referring to the subscale, the total scale, and the subscale in the clinical subgroup. Additionally, the r_{it} coefficients were analyzed in the subsamples "gender" and "age-group" (see below) and should not be below .20. Scale reliabilities, as a sign of internal construct validity, were evaluated by Cronbach's α and were supposed to exceed .80 at total scale level, .70 at scale level, and .60 at subscale level as appropriate for heterogeneous contents, while homogeneity coefficients $\alpha > .80$ would be very good and $> .90$ excellent [71,72]. In an additional EFA on item level (PCA with varimax rotation to take account for the maximum potential differences between the contents) we examined the phenotypic dimensionality of *AIDA*. Due to the construction we expected a high total congruence, as the scales were not optimized towards statistical independence but towards a joint representation of a complex construct, following basic psychosocial- and pathology-related qualities, which are usually not matching phenotypic correlational patterns.

Construct validity was examined with Pearson correlations between the *AIDA* scales and subscales and should reflect a substantial similarity between the identity-related subconstructs on the one hand (coefficients $> .30$-$.50$) but should not reflect a very high similarity (coefficients $> .70$) on the other hand in order to support the construct's subdivision.

To assess convergent and discriminant validity, Pearson correlations between *AIDA* and the *JTCI 12–18 R* on scale level were examined with reference to assumed covariances concerning identity diffusion and quality of personality functioning (maturity of character development) and non-covariance concerning basic temperament features, while coefficients should lie between .30 (medium effect size) and .50 (great effect size) to be interpreted substantially in terms of construct validity [73].

In reference to Meeus [13], we divided the sample by age into early-to-middle (12–14 years) and middle-to-late adolescence (15–18 years). Taking into account the results concerning girls reaching more often the identity status "achievement" in the interpersonal identity domain than boys [74] we also analyzed the data separately by gender to identify possible systematic differences in identity structure and development. On the item level, potential gender differences were analyzed by unidimensional ANOVAs to test for inherent item bias that would lead to item rejection and, thus, ensure items are gender neutral. On the scale level, the equivalence of results concerning reliability was evaluated in age- and gender-related subsamples to provide broad appropriateness. In the final step, t-tests on scale level regarding plain score differences between the groups were analyzed and can be interpreted as valid "developmental" group differences, as the other potential influences by age and gender on the results had been excluded empirically in the first and second step of analyses. Score differences had been examined not only concerning significance (1% level) but concerning effect size *d*, conservatively calculated by (AM1-AM2) / ((SD1 + SD2)/2) [73] and were supposed to reach a high amount ($>.80$) to avoid over-interpretation and artificial establishing of developmental differences. Content validity was analyzed by comparing the *AIDA* results between psychiatric patients with personality disorders (with assumed high amounts of identity diffusion) and healthy controls from the school sample by t-tests.

Results

Item selection and scale reliabilities

Item analysis and selection led to a final, 58-item, version of *AIDA* with very good scale reliabilities and a balanced content in line with the theoretical derived model. All remaining items matched the major selection criteria. Concerning the additional selection criteria in the subsamples, only one item (item 40: "I usually have typical 'on again – off again' relationships") showed a remarkably decreased item-total correlation with $r_{it} = .09$ in the "younger" and $r_{it} = .08$ in the "male" subsample as

a sign of age and gender specifity, while showing sufficient coefficients (.41 in the "older", .46 in the "females") in the other subsamples. But as this item is reflecting "romantic relationship" it is not surprising that the younger adolescents did not show similar covariances and we kept the item because of its high impact for stabilizing identity development in the older adolescents.

Reliability coefficients Cronbach's α were excellent for the total scale Identity-Diffusion with .94, very good for the two primary identity scales Discontinuity and Incoherence with .86 and .92 respectively, and very good for the subscales ranging from .73 to .86. Figure 2 gives a summary of scale and subscale reliabilities, range and medium item-total correlations per primary scale, and marker items per subscale. The results for scale reliabilities were stable in all subsamples (see Table 1) as required for adequate gender and age neutrality on scale level.

In an unrestricted EFA, 15 components were detected that could not be interpreted reasonably in terms of phenotypically independent subscales. While the first component showed an Eigenvalue of 14.08 accounting for 24.27% of the shared variance, the following components only contributed minor explanatory power up to 62.6% in total successively. This speaks for the expected overall congruence on phenotype-level, as all modelled contents/items are supposed to reflect pathology-related identity development but each addressing different aspects. (Figure 3)

Construct validity

Table 2 shows the intercorrelations of the *AIDA* scales and subscales. As expected, the subscales were highly correlated with their assigned primary scale about .80 but showed lower correlations with each other, as it is required for subsuming scale scores on the one hand and subdividing subscale scores on the other hand. Nevertheless, correlations $> .70$ occurred between six subscales and the correlation .76 between the two primary scales Incoherence and Discontinuity was higher than expected. Except with the subscale 1.1 "Discontinuity concerning attributes" (.61), the correlations with the total score were about .80 and higher, supporting the appropriateness of an overall sum for "Identity Diffusion".

Discriminant and convergent validity

As expected, all identity -scales and subscales showed high negative correlations with the *JTCI 12–18 R* character scale Self Directedness (–.59 – -.76) but, against our assumptions, only very low correlations with the character scale Cooperativeness (see Table 3). The correlations with the temperament scales were in line with theory, only low toward positive (.03 – .12) with the temperament factor Novelty Seeking / behavioral activation, moderate (mostly $< .30$) and toward negative with Reward Dependence / social responsiveness (–.01 – -.30) and Persistence (–.08 – -.38) and, displaying the joint relation to psychopathology, substantial positive correlations between identity development (Discontinuity and Incoherence) and Harm Avoidance / behavioral inhibition (.33 – .60) occurred.

Descriptive statistics

Data of the total sample demonstrated a sufficient normal distribution of the scores with skewness and

Scale	No. items	α	Item-total-correlation range / marker items of the subscales (one per facet)
AIDA total score: **Identity Diffusion**	**58**	**.94**	
1. Discontinuity	**27**	**.86**	**r_{it} = .30 - .66 , Ø .45**
1.1 Discontinuity concerning **attributes / goals**	9	.73	5: I could list a few things that I can do very well.(-) 58: I don't remember how I felt and thought as a child, I am now like a different person. 17: I can trust my inner voice, it usually leads me in the right direction.(-)
1.2 ... **relationships / roles**	11	.76	54: My friendships usually last only a few months. 18: I feel I don't really belong anywhere. 10: When I look in the mirror, I am often surprised and don't like how I have changed.
1.3 … **emotional self refection**	7	.76	3: I often don't know how I feel right now. 11: I'm not sure if my friends really like me.
2. Incoherence	**31**	**.92**	**r_{it} = .39 - .72 , Ø .54**
2.1 Incoherence concerning **consistent self image**	11	.86	12: When people see me in new situations, they are very surprised how I can be. 4: I feel that I have different faces that do not fit together well. 13: I often feel lost, as if I had no clear inner self.
2.2 … **autonomy / Ego Strength**	12	.84	42: When I'm alone I feel helpless. 38: If I am criticized or others see me failing, I feel really worthless and "devastated". 36: If someone has offended me, I don't want to talk to him or her ever again.
2.3 … **cognitive self reflection**	8	.76	51: I often have a block when I ask myself why I did things. 35: I am confused about what kind of person I really am.

Figure 2 Scale reliabilities α for the total score, the scales, and the subscales of AIDA in the total sample N = 357, range and medium item-total correlations r_{it} per primary scale and two marker items per subscale. (–) = reverse scoring.

Table 1 Differentiated scale reliabilities α and systematic mean score (M) differences with associated effect sizes *d* concerning gender (girls N = 192, boys N = 165) and age group (12–14 N = 149, 15–18 N = 208)

	gender differences					age differences				
	Girls		Boys			12-14		15-18		
	α	M (SD)	α	M (SD)	d	α	M (SD)	α	M (SD)	d
AIDA total score:	.94	78.12 (32.60)	.93	61.60 (27.51)	**0.55**	.92	70.85 (28.92)	.95	70.22 (33.15)	**0.02**
Identity Diffusion										
1. Discontinuity	.87	32.85 (14.73)	.83	26.74 (12.32)	**0.45**	.82	30.30 (12.91)	.89	29.83 (14.74)	**0.03**
1.1 attributes	.72	14.24 (5.64)	.75	13.00 (6.19)	**0.21**	.70	13.87 (5.91)	.75	13.53 (5.95)	**0.06**
1.2 relationships	.77	8.64 (6.21)	.74	6.44 (5.57)	**0.37**	.69	7.79 (5.69)	.80	7.50 (6.24)	**0.05**
1.3 emotional	.76	9.97 (5.39)	.73	7.30 (4.58)	**0.53**	.73	8.65 (5.22)	.78	8.80 (5.20)	**0.03**
2. Incoherence	.91	45.27 (19.64)	.92	34.86 (17.69)	**0.56**	.90	40.55 (18.58)	.93	40.39 (20.09)	**0.01**
2.1 consistent self	.87	16.23 (9.00)	.82	11.47 (7.13)	**0.59**	.82	13.94 (7.90)	.89	14.10 (8.95)	**0.02**
2.2 autonomy	.79	17.06 (7.96)	.84	13.93 (7.72)	**0.40**	.81	15.66 (8.27)	.82	15.58 (7.82)	**0.01**
2.3 cognitive	.74	11.98 (5.65)	.75	9.45 (5.39)	**0.46**	.71	10.95 (5.69)	.80	10.72 (5.65)	**0.04**

kurtosis displayed values around |1|. Table 1 shows the means and standard deviations of the AIDA scores in the subsamples to test for systematic gender and age effects using t-test, calculation of significance *p* and effect size *d*. The score differences between girls and boys were all significant except one (subscale 1.1 with p = .02) but no effect size exceeds the criteria of d > 0.80 to denote a meaningful difference. In contrast, there had been no significant score differences between the younger and the older adolescents, leading to effect sizes about zero. Thus, against our assumptions, data did not support specific group-related developmental stages of identity development.

Analyzing the frequency of T-scores below average (< 40) for the two central *JTCI 12–18 R* character scales, speaking for a high risk of current psychiatric problems, we found 18,1% for Self Directedness and 19,5% for Cooperativeness in this category in the school sample, matching the expected 15–20% of persons showing problems with self-related functionality and social-related adaptability in a typical population sample.

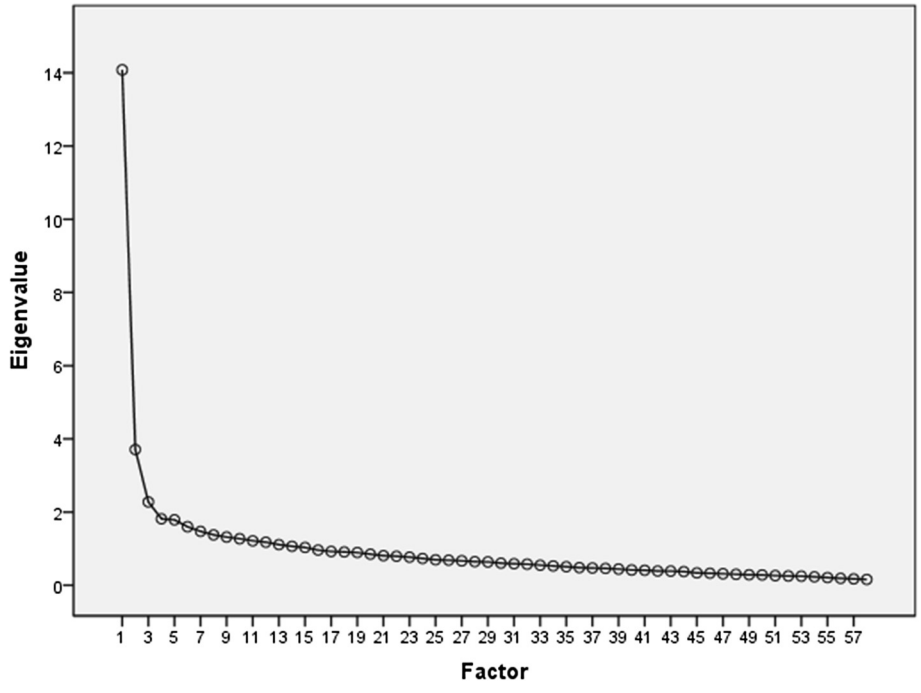

Figure 3 Screeplot for EFA on AIDA item level, 15 extracted components explaining 62.6% variance, first component 24.3%.

Table 2 AIDA scale and subscale intercorrelations

	1.	1.1	1.2	1.3	**2.**	2.1	2.2	2.3
AIDA total score: **Identity Diffusion**	**.92**	**.61**	**.81**	**.84**	**.96**	**.90**	**.78**	**.83**
1. Discontinuity		.78	.87	.80	**.76**	.78	.54	.67
1.1 attributes			.49	.39	.43	**.49**	.26	.37
1.2 relationships				.61	.68	.73	**.46**	.58
1.3 emot. self-refl.					.76	.70	.64	**.70**
2. Incoherence						.90	.87	.87
2.1 consistent self							.61	.71
2.2 autonomy								.64
2.3 cogn. self-refl.								

Criterion validity

We compared the *AIDA* scale and subscale scores between the school sample and the clinical subsample of 20 adolescents with the diagnosis of a personality disorder (18 of them Borderline Personality Disorder) and expected meaningful differences. All scales and subscales differed remarkably between the two groups with effect sizes *d* ranging from 1.04 to 2.56 standard deviations, displaying an excellent discrimination between the patients and the students (see Table 4). The subscales "1.2 Discontinuity-relationships" (d = 2.27) and "2.1 Incoherence-consistent self image" (d = 2.56) showed the strongest discrimination, while "2.2 Incoherence-autonomy" showed the lowest discrimination between the adolescents from school and from the clinical group wit PD.

In contrast to the scale scores, the scores from the six semi-open questions did not differ directly between patients and controls with sufficient effect sizes, e.g. patients did not state less hobbies or peer group affiliations than the students, but some of the evaluative variables derived from the open answers did. The expert-rated variable "sense / compliance" (d = 1.90) and the frequency of giving negative statements for "self" (d = 1.55) and "friend" (d = 0.99) showed remarkable differences between students and patients. While 97.4% of the students gave answers absolutely appropriate to the questions, displaying a high amount of compliance as well as of coherence between asked question and given answer, only 22.4% of the patients did so. 34.7% of the patients gave answers that made "quite appropriate" sense, 26.5% gave responses that were "middle appropriate", and 14.3% of the patients gave responses that were "quite freestyle" (e.g. giving nonsense answers or describing attributes and experiences when asked about hobbies). Of particular interest, displaying a high amount of self-stigmatizing attitude, is reporting negative attributes or roles (e.g. revengeful, boring, liar, looser) for self or best friend. This happened rarely by the students, (neither for self description (94.1% no negative statements) nor for the best friend (91.3%)), but often in the clinical group. Only 5.9% of the patients did not mention any negative attributes for the self, only 8.7% for the best friend and, therefore, told only positive things in this questionnaire situation.

Table 3 AIDA scale correlations with JTCI 12–18 R scales

	NS	**HA**	**RD**	**P**	**SD**	**CO**	**ST**
AIDA total score: **Identity Diffusion**	**.09**	**.59**	**-.21**	**-.23**	**-.78**	**-.09**	**.29**
1. Discontinuity	.11	.49	-.30	-.29	-.76	-.15	.18
1.1 attributes	.09	.33	-.31	-.38	-.60	-.27	.00
1.2 relationships	.05	.39	-.31	-.18	-.63	-.11	.20
1.3 emot. self-refl.	.12	.50	-.10	-.13	-.64	.03	.26
2. Incoherence	.08	.60	-.12	-.17	-.70	-.04	.33
2.1 consistent self	.08	.48	-.18	-.20	-.66	-.07	.30
2.2 autonomy	.03	.60	-.01	-.08	-.59	.00	.29
2.3 cogn. self-refl.	.10	.49	-.12	-.16	-.59	-.03	.28

NS = Novelty Seeking, HA = Harm Avoidance, RD = Reward Dependence, P = Persistence, SD = Self Directedness, CO = Cooperativeness, ST = Self Transcendence.

Table 4 Different mean scores (M) and standard deviations (SD) between the school sample and the clinical subsample with personality disorders (PD) and associated effect size *d*

	M (SD) N = 305 school	**M (SD) N = 20 clin-PD**	**Effect size d***
AIDA total score:	**65.87 (26.26)**	**129.75 (32.57)**	d = **2.17**
Identity Diffusion			
1. Discontinuity	27.72 (11.49)	56.20 (14.74)	d = **2.17**
1.1 attributes	12.95 (5.29)	20.75 (7.16)	d = **1.25**
1.2 relationships	6.48 (4.78)	19.65 (6.82)	d = **2.27**
1.3 emotional self refl.	8.30 (4.57)	15.80 (5.95)	d = **1.43**
2. Incoherence	38.15 (16.85)	73.55 (19.65)	d = **1.94**
2.1 consistent self	12.65 (7.09)	30.95 (7.20)	d = **2.56**
2.2 autonomy	15.21 (7.37)	24.30 (10.04)	d = **1.04**
2.3 cognitive self-refl.	10.29 (5.14)	18.30 (6.82)	d = **1.34**

* = Significance of all score differences were $p < .001$.

Discussion

In the new revision of *DSM-V*, the two core criteria of personality disorders will be significant impairments in "self" and "interpersonal" functioning that are assumed to be continuously distributed. According to this upcoming conceptualization of personality disorders, self-functioning is defined by the two constructs identity and self-direction. Therefore, the reliable, valid, and age-appropriate assessment of identity will be of high interest. Up to now, there is no elaborated self-rating inventory to assess identity development in healthy and disturbed adolescents, so we developed the questionnaire *AIDA* (Assessment of Identity Development in

Adolescence) and examined its psychometric properties in referred and non-referred samples.

As identity is a highly complex psychological construct, it was essential to base the new assessment tool on a broad theoretical background, including psychodynamic and social-cognitive theories as well as concepts about identity development. One of our major aims was a source-oriented conceptualization of the construct regarding psychological, social or functional constituents to overcome shortcomings of previous instruments that are mostly based on a phenotypical structure and limited in their focus either on healthy or on disturbed identity development. However, the theory-based approach makes it more difficult to prove psychometric properties of an assessment tool using the customary statistical techniques based on homogeneity and on phenotypical covariations. With "genotypical" models like that, validation with external variables is a key issue, i.e. discrimination between psychiatric categories or between other functional-based or biology-based genotypes.

Taking these challenges into account, the results of our study concerning the psychometric properties of *AIDA* are very promising, for both the adequacy of the derived model of identity as well as for the test construction on item level. Statistical item analysis and selection, based on an initial item pool established deductively by expert consensus and tested in a mixed school and clinical sample to gain optimal data variance, led to a psychometrically sound final version of *AIDA,* with very good scale reliabilities, balanced content consistent with the hypothesized model, and a minimum number of items.

Based on theory, we distinguished the two domains "Continuity" (subjective emotional self-sameness and stability over time) and "Coherence" (cognitive clarity of self-definition and consistency over situations), in line with the constructs´ dichotomy in social-cognitive psychology as well as in the psychopathology-oriented psychodynamic descriptions, to reflect the assumed basic constituents of "Identity Integration vs. Identity Diffusion". The scales are coded towards psychopathology, thus named Discontinuity and Incoherence, and composed of each three distinct theory-based subscales reflecting basic qualities of psychosocial functioning, covering and reassembling the known subconstructs of identity used in established models, especially Kernberg [21], Westen [22], Fonagy [15], and Akhtar & Samuel [50]. Despite this heterogeneity in content, the good scale reliabilities (i.e. Cronbach's Alpha which is a measure of internal consistency) argue for a high reliability and, therefore, internal construct validity in terms of statistical homogeneity. With internal consistencies of $\alpha = .94$ for the total score Diffusion, $\alpha = .86$ for Discontinuity, $\alpha = .92$ for Incoherence, and a range of $\alpha = .73$ – .86 for the subscales, *AIDA* meets the criteria for very good to excellent reliability psychometrically. These results maintained stability in subsamples concerning gender and age, implying a successful item construction that avoids systematic item bias. Adapting to the standard, we analyzed the statistical dimensionality of *AIDA* by using explorative factor analysis (EFA) modeling phenotypical covariations (see above). As expected, the correlational pattern between the *AIDA* items reflected an unspecific phenotype of 15 components with one joint factor combining the most explanation of variance, speaking for the adequateness of using a total score.

The correlational pattern between the *AIDA* scales and subscales, sharing the same higher order construct, reflected a valid internal structure in terms of construct validity. It highlighted both the appropriateness of subdividing the components of identity into subscales as well as using the total summarized scores as a measure of the global construct of identity because the subscales correlated high with their assigned primary scale and lower and with varying amounts with the other primary scale and the subscales. The often mixed phenotypically similar but clinically distinct constructs "stable attributes and goals" (1.1) and "not acting contrary / consistent self" (2.1) only correlated to $r = .49$. Similarly "stabilizing relationships and roles" (1.2) and "no over-identification / autonomy" (2.2) only correlated to $r = .46$. This indicates a successful scale construction that avoids trivial conceptual overlap and successfully captures the "psychological genotype" by further subdividing "identity related to self" and "identity related to the social world" along the two areas of identity Continuity and Coherence. Nevertheless, the high correlations (greater than .70) between six of the subscales and especially between the primary scales (.76) are speaking for the adequateness to calculate a meaningful total score for "Identity Integration vs. Diffusion" as well.

The *AIDA* scales showed promising discriminant and convergent validity by meaningful covariations with the *JTCI 12–18 R* personality factors in line with the predictions. We expected the pathology-related personality factors Self Directedness / self-related functionality, Cooperativeness / social-related adaptivity (both character factors) and Harm Avoidance / behavioral inhibition (temperament factor) [56,64] to correlate substantially ($>.30$) with both *AIDA* scales Discontinuity and Incoherence, both constructed as an indicator for pathology-related identity diffusion. In contrast, we expected only minor correlations with the other temperament factors, seen as closer related to style of behavior than to an impaired personality functioning. As expected, all identity -scales and subscales showed high negative correlations with the *JTCI 12–18 R* character scale Self Directedness (–.59 – -.76), substantial positive

correlations with the temperament scale Harm Avoidance (.33 – .60), and only low to moderate correlations (less than .30) with the other scales. But, contrary to our assumptions, only very low correlations with the character scale Cooperativeness (.03 – -.27) occurred. Thus, identity integration seems to be much closer to self-related personality functioning (scale Self Directedness) than to social adaptability (scale Cooperativeness). A remarkable result are the low correlations (.03 -.12) of all identity scales with the temperament factor Novelty Seeking that (in part) represents impulsive behaviour. This is a clear indication that in contrast to other identity questionnaires our operationalization of identity successfully kept out trait impulsivity. Similarly, the low correlations between the *AIDA* subscale "Incoherence-autonomy vs. over-identification" and the temperament factor Reward Dependence / social responsiveness (–.01) and the character factor Cooperativeness (.00) may speak for the successful attempt to avoid trivial item overlap between alternative constructs in general and an overlap with sociability in particular.

Little is known about the development of identity over time and if the process of identity formation is different for girls and boys. According to our data, we can assume that the way in which younger adolescents describe their identity using the *AIDA* items is not much different from that of older adolescents (no significant differences, effects sizes around zero). Although, of course, adolescents do differ and develop in terms of identity integration with age, there seemed to be no systematic "normative" age levels and no typical developmental stages per age could be found. Therefore we can assume that identity development as it is measured by *AIDA* reflects age neutral Identity Integration vs. Identity Diffusion. Thus, separate population norms would be redundant for age groups. In contrast, the differences between girls and boys were significant in all scales and subscales on the 1% level, except subscale 1.1 (Discontinuity concerning attributes and goals) with medium effect sizes for the primary scales (.45 and .56). The medium effect size is large enough to warrant continued separation of gender at this stage of instrument development, until further data from the studies currently underway is analyzed.

Our approach to integrate some semi-open questions to simulate an interview-like situation and to catch some additional facets of identity diffusion did succeed partly and is not fully explored in its potential yet. It delivered at least one valid additional content that is integrated in Westen's concept [22] but missing on the traditional item level in *AIDA*, the concept of "self-stigmatizing" which is described as a sign of disturbed identity development. The frequency of "giving negative statements" for self and best friend seems to differentiate remarkably between students and patients in general, as the students rarely (under 10%) labeled themselves or their best friend in negative terms (e.g. "a looser"), while the patients did so frequently (over 90%). But the significance of these results concerning the evaluation of adolescent identity integration needs further investigation.

As we have outlined above, disturbance of identity is seen as one of the core components of of personality disorders. Therefore, an instrument that is designed to capture disorders of identity in adolescents should have the ability to distinguish between normal adolescents and those who suffer from a personality disorder. Criterion validity was achieved, as the two *AIDA* primary scales, as well as all subscales, revealed an excellent discrimination between patients with personality disorders and normal controls with effect sizes (d) between 1.04 and 2.56 standard deviations. The subscales "stable relationships and roles" (d = 2.27) and "consistent self concepts" (d = 2.56) differed the most (comparable to an IQ difference of 85 to 122.5), while the subscale "autonomy vs. over-identification" differed (though above criteria) the least (d = 1.04) between adolescents with and without PD. Distinct relationships between subconstructs of identity development and different diagnoses will be of continued interest. Future studies will have to explore the effectiveness of *AIDA* to detect changes in identity integration as identity consolidation is one of the major aims of psychotherapy with personality disordered adolescents.

Limitations

We did not assess psychiatric disorders in the school sample. But, with respect to the results of epidemiological studies, we can assume that up to 15–20% of this adolescent sample of the general population show minor to major signs of mental problems. The frequency of T-scores below average (< 40) for the *JTCI 12–18 R* character scales Self Directedness (18,1%) and Cooperativeness (19,5%) in the school sample gives support for this assumption and, thus, a successful study design with a representative population sample, though a personality inventory can never be the sole basis for a psychiatric diagnosis. Moreover, this gives rise to the expectation that the differences in the *AIDA* scores between our clinical group and a completely healthy control group would be even higher.

Further research and the comparison of developmental stages and pathways into adulthood between school samples from different countries and clinical samples with different diagnoses or special developmental problems will be of high interest concerning not only the criterion validity but also the construct validity of *AIDA*. With 52 adolescents, the clinical sample was too small and heterogeneous to build more sufficiently large

diagnose-related groups for e.g. Eating Disorders or Conduct Disorders and to analyze systematic differences in *AIDA* results between them. Additionally, test-retest reliability was not measured and should be examined in further studies.

The scale structure and its subdivision reflects the theory-based "genotype" of the complex construct "Identity Integration vs. Identity Diffusion" in terms of the assumed psychological, social and functional constituents and should be seen as a summary of all relevant subconstructs. However, additional studies are needed to address the genotypical approach not only concerning psychosocial but also possible biological constituents (i.e. biological markers of personality disorders).

Nearly all theoretically described contents could be kept in the scales in a balanced way. However, some contents, especially all items reflecting sexuality and other potentially embarrassing issues, could not be kept because of dramatically weak psychometric properties. This is a sign of non-adequacy and non-applicability of these contents in the form of a self-report item and should not be taken as a sign of unimportance of these facets concerning identity development. To the contrary, for clinical evaluation these contents should be assessed, but within a personal therapeutic relationship. Similarly, the breadth of the integrated contents, especially on subscale and facet level, should not be overinterpreted. For example the facets "autonomous affect-regulation" and "subjective self-sameness" are each represented by only two power-items, and thus adequately representative in our very condensed model of identity but, of course, are not described in an exhaustive way.

Conclusion

The present data suggest that *AIDA* is a reliable and valid instrument to assess normal and disturbed identity in adolescents and discriminates well between patients with PD and healthy controls. It was designed based on a broad range of theoretical approaches from the field and in a joint international project with expert consensus, focussing on a deductive scale construction, on clarity, culture, and -age, and -gender fairness of the items. Thus, studies addressing the sources of behavior or personality disorders as well as studies comparing identity development in different countries or adolescent subsamples remains of high interest. Moreover, development of identity over time should be analyzed with longitudinal approaches, as it does not seem to be simply related to age. Several translation and validation studies for *AIDA* (Chile, Brazil, Mexico, Spain, Canada, Kosovo, Croatia, Bulgaria, Serbia) as well as studies for further validation with detailed analyses of covariation with personality development on the subscale level, of discrimination between distinct psychiatric disorders like anxiety, attention, and eating disorders in contrast to PD and for providing population norms, are already in progress in cooperation with the authors.

Competing interests
The authors declare that they have no competing interests.

Authors' contributions
KG, PF, SS and KS developed AIDA. KG designed the study, performed the statistical analysis and was the main writer of the manuscript. KS and PF wrote parts of the manuscript. EJ, OP, MB and SS collected the data. All authors read and approved the final manuscript.

Author details
[1]Child and Adolescent Psychiatric Hospital, Psychiatric University Hospitals Basel, Basel, Switzerland. [2]Weill Medical College of Cornell University, New York, USA. [3]Practice for Child and Adolescent Psychiatry, Frankfurt/Germany, and University of Applied Sciences FHNW, Basel, Switzerland. [4]Faculty of Medicine, Justus Liebig University, Giessen, Germany.

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Identity development in adolescents with mental problems

Emanuel Jung[1*], Oliver Pick[1], Susanne Schlüter-Müller[2,3], Klaus Schmeck[1] and Kirstin Goth[1]

Abstract

Background: In the revision of the Diagnostic and Statistical Manual (*DSM-5*), "Identity" is an essential diagnostic criterion for personality disorders (self-related personality functioning) in the alternative approach to the diagnosis of personality disorders in Section III of DSM-5. Integrating a broad range of established identity concepts, *AIDA* (Assessment of Identity Development in Adolescence) is a new questionnaire to assess pathology-related identity development in healthy and disturbed adolescents aged 12 to 18 years. Aim of the present study is to investigate differences in identity development between adolescents with different psychiatric diagnoses.

Methods: Participants were 86 adolescent psychiatric in- and outpatients aged 12 to 18 years. The test set includes the questionnaire *AIDA* and two semi-structured psychiatric interviews (*SCID-II, K-DIPS*). The patients were assigned to three diagnostic groups (personality disorders, internalizing disorders, externalizing disorders). Differences were analyzed by multivariate analysis of variance MANOVA.

Results: In line with our hypotheses, patients with personality disorders showed the highest scores in all AIDA scales with T>70. Patients with externalizing disorders showed scores in an average range compared to population norms, while patients with internalizing disorders lay in between with scores around T=60. The AIDA total score was highly significant between the groups with a remarkable effect size of f= 0.44.

Conclusion: Impairment of identity development differs between adolescent patients with different forms of mental disorders. The *AIDA* questionnaire is able to discriminate between these groups. This may help to improve assessment and treatment of adolescents with severe psychiatric problems.

Keywords: Identity, Assessment, Personality disorder, Adolescence, Psychopathology

Background

Identity is a broadly discussed construct and is linked to different psychodynamic [1,2], social cognitive [3,4], and philosophical theories (see Sollberger in this issue). Erikson [1] defines identity as a hybrid concept providing a sense of continuity and a frame to differentiate between self and others, which enables a person to function autonomously. Ermann [5] describes identity similarly as aligned in a transitional space between a given person and his or her community. On the one hand, a person has a sense of uniqueness regarding the past and the future; on the other hand, he or she sees differences as well as resemblances to others. "This sense of coherence and continuity in the context of social relatedness shapes life" [5], p. 139.

Establishing a stable identity is one major development task in adolescence [6]. These challenges of identity formation go along with identity crises that are normal and temporary phenomena in mastering age-related developmental tasks in adolescence [6]. According to Kernberg [7], the transformation of the physical and psychological experiences of young people and the discrepancy between the sense of self and the others' view of the adolescent lead to identity crises. Erikson [1] emphasizes the need for resolution of identity crises by synthesizing previous identifications and introjections into a consolidated identity.

In contrast to the non-pathological identity crisis, we use the concept of identity diffusion as a pathological identity development that is viewed as a psychiatric

* Correspondence: Emanuel.Jung@upkbs.ch
[1]Child and Adolescent Psychiatric Hospital, Psychiatric University Hospitals, Basel, Switzerland
Full list of author information is available at the end of the article

syndrome underlying all severe personality disorders [7,8]. According to Kernberg's theory of personality disorders [9], borderline personality organization is hallmarked by identity diffusion. Patients with identity diffusion have a non-integrated concept of the self and significant others so that a clinician cannot get a clear picture of the patient's description of himself and of significant others in his life [10]. There is often no commitment to jobs, goals and relationships as well as an avoidance of ambivalence associated with a painful sense of incoherence [11].

Probably due to present changes in society with transitions in family and work, the number of patients with identity diffusion increases over time [5,12,13]. In contrast to the understanding outlined above, other authors (e.g. Marcia's identity status paradigm [14]) view identity diffusion as a concept containing a broad range from adaptability to psychopathology like borderline personality disorders. From an optimistic point of view, identity diffused individuals are flexible (due to the lack of commitment) and seem to accommodate well to the fast-moving technological world [14]. For other authors [15], post-modern life as a whole is hallmarked by a condition of diffusion. Whether one agrees with the post-modern view or not, the development of healthy and disturbed identity is a topic of high interest. In the following, new conceptualizations, methods of treatment, and diagnostic instruments of healthy and disturbed identity are discussed. Goth et al. [16] presented an integrative understanding of healthy and disturbed identity and developed the self-report instrument AIDA (Assessment of Identity Development in Adolescence) to assess pathology-related identity development in adolescence. In the present study, the potential of *AIDA* is proved by investigating differences in identity development between adolescents with different psychiatric diagnoses.

New conceptualizations: identity concepts in DSM-5

The *DSM-IV* includes identity disturbance as a criterion of borderline personality disorder and defines it as "markedly and persistently unstable self-image or sense of self" [17], p. 654. In the revision from *DSM-IV* to *DSM-5* [18,19], the concept of identity is a central part of a new conceptualization of personality disorders in the alternative approach to the diagnosis of personality disorders in Section III of DSM-5 (see Schmeck et al. in this issue). The core criteria of personality disorders are composed of impairments in personality functioning in the two domains of self-functioning (self-direction and identity) and interpersonal functioning (empathy and intimacy). Identity is defined as the "experience of oneself as unique, with clear boundaries between self and others; stability of self-esteem and accuracy of self-appraisal; capacity for, and ability to regulate, a range of emotional experience" [20]. The new model is placed in Section III of DSM-5 to stimulate further research in this field.

New method of treatment: Adolescent Identity Treatment (AIT)

Research of the last 15 years reveals increasing evidence that personality disorders are a prominent form of psychopathology in adolescence [21-24]. Personality disorders prior to age of 18 years can be reliably diagnosed [25,26]. They have a good concurrent [24,27] and predictive validity [22] with adequate internal consistency [28] and similar stability to personality disorders in adulthood [27,29,30]. Thus, symptoms of personality disorders in adolescence can be diagnosed and targeted for treatment [11,31,32]. Paulina Kernberg [10] described a model for understanding the impact of identity diffusion as a pathogenic mechanism in developing a personality disorder in adolescence and stressed the need to differentiate between normal identity crisis and pathological identity diffusion for a targeted therapeutic intervention. These ideas lead to the development of the psychodynamic treatment approach "Adolescent Identity Treatment" (*AIT*) [33]. This treatment focuses on identity diffusion in adolescence and is designed to help young patients to establish satisfying relationships, gain self-esteem and clarify aims in life.

New diagnostic instrument: the questionnaire AIDA (Assessment of Identity Development in Adolescence)

Our research group developed the questionnaire *AIDA - Assessment of Identity Development in Adolescence* [16] to assess pathology-related identity development in healthy and disturbed adolescents aged 12 to 18 years in self-report for diagnostic and prognostic issues. Thus, *AIDA* is predestinated to be used as a research tool to evaluate therapy efficacy of *AIT* as well as of every therapy addressing improvement in self-related personality functioning related to constructs described below.

Discourses about identity are heterogeneous [12]. With respect to a broad range of theoretical descriptions about identity development, two domains have been distinguished for constructing the *AIDA*. In line with the constructs' dichotomy in social-cognitive psychology as well as in the psychopathology-oriented psychodynamic descriptions the AIDA model distinguishes between the two dimensions "Continuity" and "Coherence", serving as a well elaborated theoretical framework to find a meaningful and distinct substructure of the higher order construct "identity integration vs. identity diffusion" (for a detailed description see [16]). Following strict rules of deductive test construction and focusing on clear-cut constructs, we integrated aspects of operationalizations of identity diffusion by other authors like Kernberg [34], Westen [35] and Akhtar & Samuel [36] and additionally

differentiated the aspects of psychosocial functioning "self-related", "social-related", and "related to mental representations / ability" following e.g. Fonagy (emotional and cognitive self-reflection is viewed as an elementary basis for identity development [37]) in order to substructure the construct along its hypothesized constituents (see Table 1).

The construct "Continuity" represents the vital experience of "I" and subjective emotional self-sameness with an inner stable time line. High "Continuity" is associated with the stability of identity-giving goals, talents, commitments, roles, and relationships, and a good and stable access to emotions as well as the trust in the stability of them. A lack of Continuity (i.e. high "Discontinuity") is associated with a missing self-related perspective, no feeling of belonging and affiliation, and a lack of access to emotional levels of reality and trust in the durability of positive emotions.

The construct "Coherence" stands for clarity of self-definition as a result of self-reflective awareness and elaboration of the "ME", accompanied by consistency in self-images, autonomy and Ego-strength, and differentiated mental representations. A lack of Coherence (i.e. high "Incoherence") is associated with being contradictory or ambivalent, suggestible and over-matching, and having poor access to cognitions and motives, accompanied by superficial and diffuse mental representations. The scales are coded towards psychopathology. High scores in the AIDA scales "Discontinuity" and "Incoherence" are indicators of an identity diffusion.

The current study contrasts the identity development of personality disordered adolescents with the identity development of adolescents suffering from internalizing or externalizing disorders. In child and adolescent psychiatric research a procedure like this is often used to clarify the question if discrepancies from a normal sample are specific for a special diagnostic group or if they are a characteristic of mental disorders in general. As outlined above, identity problems are one of the core criteria of personality disorders so that we hypothesize adolescents with personality disorders reaching significantly higher scores in identity diffusion in comparison to other clinical groups. Up to now there are no studies about systematic differences in the level of identity problems in non-PD adolescent patients so that our second hypothesis is based on clinical experience. Patients with

Table 1 Theory-based suggestion for a meaningful substructure of the construct "Identity Integration vs. Identity Diffusion" and its operationalization into AIDA scales, subscales, and facets

Identity integration vs. Identity diffusion		
Scale 1:	Scale 2:	
Identity-Continuity vs. **Discontinuity**	Identity-Coherence vs. **Incoherence**	
Ego-Stability, intuitive-emotional "I" ("Changing while staying the same")	Ego-Strength, defined "ME" ("non-fragmented self with clear boundaries")	Psychosocial functioning
Sub 1.1: **Stability in attributes** / goals vs. lack of perspective	Sub 2.1: **Consistent self** image vs. contradictions	**Self-related** intrapersonal "Me and I"
F1: capacity to invest / stabilizing commitment to interests, talents, perspectives, life goals	F1: same attributes and behaviors with different friends or situations, consistent appearance	
F2: stable inner time-line, historical-biographical self, subjective self-sameness, sense of continuity	F2: no extreme subjective contradictions / diversity of self-pictures, coherent self-concept	
F3: stabilizing moral guidelines and inner rules	F3: awareness of a defined core and inner substance	
Sub 1.2: **Stability in relations** / roles vs. lack of affilitation	Sub 2.2: **Autonomy** / ego-strength vs. over-identification, suggestibility	**Social-related** interpersonal "Me and You"
F1: capacity to invest / stabilizing commitment to lasting relationships	F1: assertiveness, ego-strength, no over-identification or over-matching	
F2: positive identification with stabilizing roles (ethnic - cultural - family self)	F2: independent intrinsic self-worth, no suggestibility	
F3: positive body-self	F3: autonomous self (affect) regulation	
Sub 1.3: Positive **emotional self reflection** vs. distrust in stability of emotions	Sub 2.3: positive **cognitve self reflection** vs. superficial, diffuse representations	**Mental representations** accessability and complexity concerning own and others' emotions / motives
F1: understanding own feelings,good emotional accessibility	F1: understanding motives and behavior, good cognitive accessibility	
F2: understanding others´ feelings, trust in stability of others' feelings	F2: differentiated and coherent mental representations	

severe anxiety disorders and major depression experience a substantially reduced self-esteem which could have an impact on identity development. In contrast, patients with externalizing disorders boost their self-esteem by externalizing their problems. Based on these observations we hypothesize elevated scores of identity diffusion in patients with internalizing disorders in comparison with patients with externalizing disorders.

Methods

Participants and procedures

Participants were 86 inpatients and outpatients of a child and adolescent psychiatric university hospital (N= 75) and a child and adolescent psychiatric practice (N=11). Inclusion criteria were age 12–18 years, sufficient linguistic and cognitive skills to master the written task and no current psychotic episode. The sample consisted of 30 boys (34.9%) and 56 girls (65.1%) in the age range from 12–18 years (mean age 15.24, SD 1.77). The study was approved by the local ethics committee and written informed consent was given. Taking into account the results of the diagnostic interviews *K-DIPS* (Children – Diagnostic Interview for Psychiatric Diseases) [38] and *SCID-II* (The Structured Clinical Interview for DSM-IV, Axis II) [39] (see below) and of a classification conference, the patients were assigned to one of the three diagnostic groups "personality disorder (PD)", "internalizing disorder (internal)", or "externalizing disorder (external)" (see Table 2). Patients who clearly fulfilled the DSM-IV criteria of a personality disorder were allocated to the PD-group independently of axis I comorbidities like anxiety or depression. Patients with internal or external problems were attributed to the correspondent groups, if the diagnoses were unambiguous and no comorbidities were detected. We excluded patients from further analysis if they showed comorbid internalizing and externalizing problems or other psychiatric disorders like psychoses or pervasive developmental disorders.

From the 86 patients,

- N= 24 were assigned to the "PD"-group according to the results of the SCID-II interview (15 Borderline PD (F60.3), 5 other cluster-B PD, 3 cluster-C PD and 1 cluster-A PD).
- N= 22 were assigned to the group "internal" (15 depressive disorders (F33), 5 anxiety disorders (F40) and 2 emotional disorders (F93)).
- N= 10 patients were assigned to the "external"-group (7 ADHD (F90, F90.1, F98.8) and 3 conduct disorder (F91)).
- N= 30 could not be assigned to one of the research groups because of comorbidities or non-target diagnoses.

In this process we took especially care to create "pure" diagnostic groups to enable valid interpretations of differences between these types of psychiatric disorders in terms of differences in identity development.

Measures

AIDA

AIDA (Assessment of Identity Development in Adolescence) [40] is a self-report questionnaire for adolescents from 12 to 18 years to assess pathology-related identity development. Its construction was based on a broad description of the field integrating classical approaches and constructs from psychodynamic and social-cognitive theories, focusing on a comprehensive and methodological

Table 2 Mean score (M) and standard deviation (SD) differences with associated significance level p and effect size f in the different diagnostic groups: personality disorder (PD), internalizing disorder (internal), and externalizing disorder (external)

	Differences between diagnostic groups					
	PD	Internal	External			
	N= 24	N= 24	N=10			
	M (SD)	M (SD)	M (SD)	F	p*[1]	f*[2]
AIDA total score: **Identity diffusion**	135.96 (27.41)	96.82 (39.22)	60.50 (30.18)	13.485	.000***	0.44
1. Discontinuity	58.29 (13.02)	42.23 (18.80)	28.70 (12.66)	9.588	.000***	0.36
1.1 attributes	23.92 (16.05)	19.09 (11.48)	14.40 (6.10)	1.484	.230	0.08
1.2 relationships	20.17 (6.45)	13.00 (7.92)	9.20 (7.38)	7.030	.000***	0.29
1.3 emotional self-refl.	16.29 (5.54)	13.18 (6.65)	5.10 (3.64)	9.751	.000***	0.36
2. Incoherence	74.96 (19.21)	51.55 (25.78)	31.80 (22.07)	9.615	.000***	0.36
2.1 consistent self	32.00 (6.24)	20.82 (9.84)	13.50 (9.93)	13.106	.000***	0.43
2.2 autonomy	26.17 (8.60)	19.77 (8.49)	10.20 (8.43)	8.375	.000***	0.33
2.3 cognitive self-refl.	19.50 (5.88)	14.00 (5.97)	8.10 (6.26)	7.279	.000***	0.35

*[1]: Significance p ***=0.1% level, *[2]: effect size f>0.10 small, f>0.25 medium, f>0.40 big.

optimized assessment. The 58 5-step format items were coded towards pathology and add up to a total score ranging from "identity integration to identity diffusion". To facilitate scientific communication on the one hand and research concerning possible specific relations to external variables on the other hand, the integrated subconstructs constituting "Identity Diffusion" together are formulated in terms of distinct scales and subscales. The differentiated scales and subscales are referring to distinct psychosocial or functional constituents without regarding them to be statistically independent variables (see Table 1).

In a mixed school (N = 305) and clinical sample (N = 52) *AIDA* showed excellent total score (Diffusion: α = .94), scale (Discontinuity: α = .86; Incoherence: α = .92) and subscale (α = .73-.86) reliabilities [16]. Construct validity could be shown by high intercorrelations between the scales supporting as well the subdifferentiation as the subsumed total score. EFA on item level confirmed a joint higher order factor explaining already 24.3% of variance. High levels of Discontinuity and Incoherence were associated with low levels in Self Directedness (*JTCI 12–18 R* [41,42]), an indicator of maladaptive personality functioning. Criterion validity could be demonstrated with both AIDA scales differentiating between patients with a personality disorder (N = 20) and controls with remarkable effect sizes (d) of 2.17 and 1.94 standard deviations. Several translations of *AIDA* in different languages are in progress and show similar promising results concerning psychometric properties (for the Mexican version of *AIDA* see Kassin & Goth, this issue).

SCID-II and K-DIPS

As the aim was to explore the thresholds between healthy development, identity crisis and identity diffusion, valid and broad measures for psychopathology were needed. We used the two well-established semi-structured diagnostic interviews *SCID-II* [39] and *K-DIPS* [38]. *SCID-II* (The Structured Clinical Interview for *DSM-IV* Axis II) is designed to assess personality disorders according to *DSM-IV* criteria. Administration time is about 60–90 minutes. *K-DIPS* (Children – Diagnostic Interview for Psychiatric Diseases) is designed to assess axis I psychopathology in children and adolescents according to *ICD-10* and *DSM-IV* criteria, and takes about 90–120 minutes to administer.

Statistical analysis

We used the Statistical Package for the Social Sciences (SPSS 19 for Windows) for data analyses. Differences between the three groups of psychiatric disorders in AIDA scores were analyzed by multivariate analysis of variance MANOVA with the factor "pathology" (PD, internal, external). The factor "sex" was integrated as a covariate since systematic differences had been detected between boys and girls in the validation sample and different population norms had been suggested [16]. Effect size *f* is supposed to be big with >.40 but should be at least medium with >.25 to avoid overinterpretation of significant group differences. The sample size is sufficient to test for big effect sizes with significance level p<.05.

Results

In line with our hypotheses, the patients with personality disorders showed the highest scores in all AIDA scales, the patients with externalizing disorders the lowest scores, while the patients with internalizing disorders scored in between (see Table 2). For the AIDA total score "Identity Diffusion" the effect size of this highly significant group difference was big with f= 0.44. The two primary scales "Discontinuity" and "Incoherence" seemed to differentiate with a similar quality between the groups, both reaching nearly big effect sizes with f= 0.36. On AIDA subscale level, distinct potential to differentiate between types of pathology was detected. While the identity component "Incoherence concerning consistent self-picture" differentiated with a big effect size of f= 0.43 between the groups, the subscale "Discontinuity concerning attributes and goals" did not significantly differentiate between the groups. The other subscales all reached high significance and medium effect sizes in differentiation.

Figures 1 and 2 are displaying the presented group differences with T-values, thus the meaning of score levels can be interpreted directly. The patients with PD lie clearly above the population norm in their levels of identity diffusion, reflecting a high clinical relevance. The patients with internalizing disorders are slightly above the population norm on total and primary scale level, reflecting an elevated level but below clinical severity, while patients with externalizing disorders do not seem to have systematic differences in their pathology-related identity development compared to a public school sample.

Discussion

The reformulation of the diagnostic category "Personality Disorders" was one of the highly discussed changes in the revision of DSM-IV to DSM-5. The alternative approach to the diagnosis of personality disorders in Section III of DSM-5 defines a combination of impairments in "self" and "interpersonal" functioning as core criteria of personality disorders. "Self-related personality functioning" is composed of the two constructs "Self-direction" and "Identity". As indicated by placing the new approach in section III of the new manual further research is recommended to unify the different conceptualizations of personality disorders. To perform this research, valid and reliable tools to assess the core constructs of PD are urgently needed.

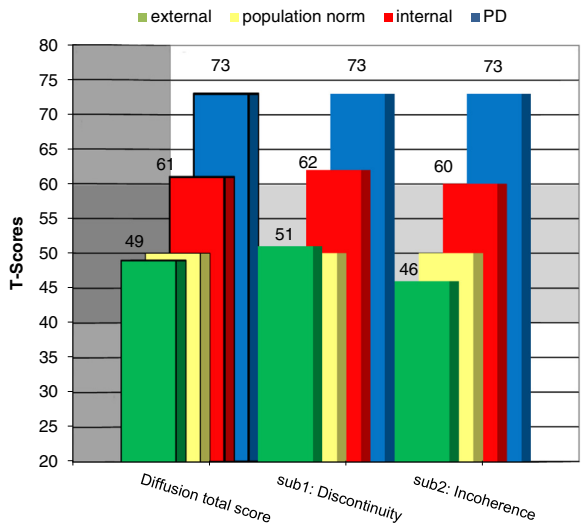

Figure 1 Comparison of T-values in AIDA total and primary scales between the diagnostic groups and the norm population (all T=50).

The new self-report inventory AIDA assesses pathology-related identity development in adolescence with good reliability and validity [16]. We investigated the power of the inventory to differentiate between adolescents with different psychiatric disorders in respect to normal and disturbed identity development.

In line with our assumptions, the results clearly indicated a high discriminative power of *AIDA* concerning different psychiatric groups, each assigned theoretically with different levels of clinically relevant identity diffusion. The patients with PD, mostly borderline or other B-type, scored not only remarkably higher than the healthy norm population but also higher than the other patient groups with internalizing or externalizing disorders. Moreover, these findings indicate that identity diffusion as it is defined in the AIDA model is a

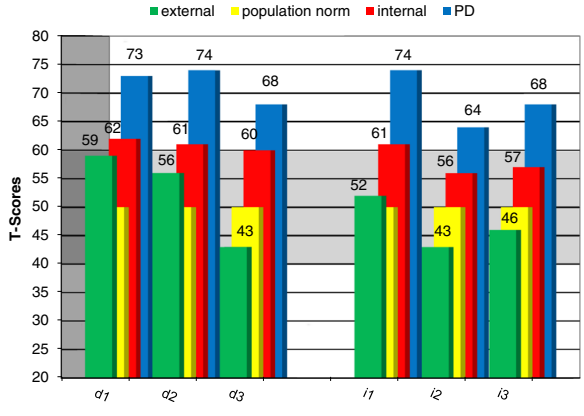

Figure 2 Comparison of T-values in AIDA subscales between the diagnostic groups and the norm population (all T=50).

distinguishing mark of PD, not only of psychiatric impairment in general. While patients with PD (Diffusion total score ∅ T= 73) showed highly elevated scores, patients with internalizing disorders, mostly with clinically relevant depression, showed only slightly elevated scores concerning identity diffusion (Diffusion total score ∅ T= 61) and patients with externalizing disorders, mostly diagnosed with ADHD, did not differ from the school population in their identity development at all (Diffusion total score ∅ T= 49).

One of the main aims of *AIDA* is to differentiate between healthy identity integration, current identity crises, and severe identity diffusion. Patients with internalizing disorders scored slightly above the population norm, which may be interpreted as the presence of a current identity crisis. We intended to build homogenous psychiatric groups to also find possible "typical profiles" of identity development and may detect distinct relations between AIDA subscales and type of pathology to help defining the threshold between "crisis" and "diffusion". But most of the subscales did not differ in their characteristics compared to the primary scales. Thus, further research is needed in this field. Only in the "external" group noticeable differences seemed to occur: patients with externalizing behavior problems had higher levels of "good emotional access to own and others' feelings" (sub 1.3) and of "autonomy and Ego-strength" (sub 2.2) compared to the healthy controls, while their "stabilizing commitments to interests and goals, subjective selfsameness" (sub 1.1) was nearly as impaired as in the patients of the "internal" group.

It would be comprehensible, however, that patients with externalizing behavior problems (e.g. with conduct disorders) have a relatively consistent self-image (e.g. in terms of a stable criminal identity like "I am a bad guy and feel confident about that.") and perceive themselves as autonomous (e.g. "I do whatever I want."), but in our sample only 3 patients with conduct disorder are integrated, thus a separate examination is not possible (see "Limitations" below). With the limited number of patients in the "externalizing disorder" group it is far too early to draw far reaching conclusions from our results. It is essential to enlarge this group with much more patients to be able to differentiate between adolescents with pure ADHD and those with conduct disorder problems.

In general, it is in line with the AIDA-definition of pathology-related identity development that only patients with a personality disorder show elevated scores. The frequently existing artificial overlap in assessing "contradictory behavior" (as part of all descriptions of identity diffusion) and "impulsive behavior" (as part of externalizing behavior), known from a lot of inventories assessing identity-related constructs, is avoided carefully in the questionnaire *AIDA*. Given this, *AIDA* might

provide the possibility to differentiate those patients with ADHD from those with emerging antisocial personality disorder.

Limitations

The criteria for assignment to the three diagnostic groups were strict in order to build homogenous groups. In a classification conference, where we took the results of the diagnostic interviews and clinical experience into account, heterogeneity and comorbidity could be decreased at the cost of a large residual category. This residual category includes 30 of 86 patients which could not be assigned to one of the research groups. Therefore especially the number of patients in the externalizing group was quite low. Furthermore, the group of patients with internalizing problems remains heterogenic. Compared to the other diagnostic groups, the "internal" group shows relatively large standard deviations in their AIDA scores. We can't exclude that there might be patients in this group who will develop manifest personality disorders in the future. In this study we used the semi-structured diagnostic interview *SCID-II* [39] that has been developed to assess personality disorders in adults. Along with the ongoing revisions of *DSM* and *ICD* it would be very helpful if assessment instruments could be established that are focused on the symptomatology of adolescents with severe impairment of personality functioning.

From a theoretical perspective, it is very useful to know that mean differences in the AIDA scores exist between diagnostic groups, but mean differences do not translate automatically into accurate diagnoses. For diagnostic purposes, we have to consider whether cut-off points regarding identity diffusion and/or crisis might be useful. Once those markers are established, we could determine false positive and false negative rates. Furthermore, when comparing groups, such as adolescents with differing diagnoses, it is important to establish the equivalence of the groups on as many potentially confounding variables as possible. Including more variables (e.g. socio-economic status, level of education, type of parenting received, relationship status of their parents, or arrest records) as well as in-group comparisons or symptom-oriented rearrangements of the sample could lead to new interesting results and show clearly that the differences in the observed identity functioning have more to do with the psychiatric condition than with other variables.

All in all, further research with a bigger sample and even more homogenous groups is needed to highlight distinct profiles and to examine the thresholds between identity crisis and diffusion in detail to develop a more accurate conceptualization of the construct "Identity crisis". For this aim, longitudinal studies would be of high interest to model the prognostic power of different levels of identity development on subscale level as well as possible changes over time.

Conclusion

"Identity" is a construct of high interest and is discussed as an essential diagnostic criterion for personality disorders in the new *DSM-5*. For diagnostic purposes, *AIDA* seems to be a useful self-report questionnaire for adolescents from 12 to 18 years to assess pathology-related identity development in terms of this self-related personality function. As patients with personality disorders showed the highest AIDA scores compared to patients with other diagnoses and lied clearly above the population norm in their levels of identity diffusion, remarkable criterion validity can be assumed for this questionnaire and the use of *AIDA* can be recommended for several clinical tasks.

Competing interests

The authors declare that they have no competing interests.

Authors' contributions

EJ and KG were the main writer of the manuscript. KG designed the study and performed the statistical analysis. KS, SS and OP wrote parts of the manuscript. EJ, OP and SS collected the data. All authors read and approved the final manuscript.

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Author details

[1]Child and Adolescent Psychiatric Hospital, Psychiatric University Hospitals, Basel, Switzerland. [2]Practice for Child and Adolescent Psychiatry, Frankfurt, Germany. [3]University of Applied Sciences FHNW, Basel, Switzerland.

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Assessment and Treatment of Identity Pathology During Adolescence

Susanne Schlüter-Müller[1,2*], Kirstin Goth[2], Emanuel Jung[2], Klaus Schmeck[2]

[1]Praxis, Frankfurt am Main, Germany
[2]Department of Child and Adolescent Psychiatry, University of Basel, Switzerland

***Corresponding author:** schlueter-mueller@praxis-schlueter-mueller.de

Abstract

Personality disorders can be seen as patterns of maladaptive personality traits that have their onset during childhood or adolescence and that have an impact on the individual throughout the life span. Identity disturbance is seen as the central construct for detecting severe personality pathology—and, most notably, borderline personality disorder—in adults and adolescents. Therefore, in the revision of the *Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition,* the construct of "identity" has been integrated as a core diagnostic criterion for personality disorders.

One of the most central tasks of normal adolescent development is the consolidation of identity. Crises in the development of identity usually resolve into a normal and consolidated identity with flexible and adaptive functioning. By contrast, identity diffusion is viewed as a lack of integration of the concept of the self and significant others; it is also seen as the basis for subsequent personality pathology, including that of borderline personality disorder, which leads to a broad spectrum of maladaptive and dysfunctional behaviors.

To measure identity pathology and its improvement with treatment, we developed a self-report questionnaire entitled Assessment of Identity Development in Adolescence to establish a reliable, valid, and time-efficient inventory to represent a dimensional concept of healthy and impaired personality development. The reliability of this self-report questionnaire is excellent, and the total score differentiated significantly between controls and patients with personality disorders.

Adolescent Identity Treatment is a treatment model that focuses on identity pathology as the core characteristic of personality disorders. This model integrates specific techniques for the treatment of adolescent personality pathology on the background of object-relation theories and modified elements of Transference-Focused Psychotherapy. Moreover, psychoeducation, behavior-oriented home plans, and family work support the therapeutic process of the adolescent.

Keywords: adolescence, Adolescent Identity Treatment (AIT), Assessment of Identity Development in Adolescence (AIDA), identity, identity diffusion, personality disorder

Introduction

In the revised *Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition* (DSM-5), the definition of personality disorder and its diagnoses have not been changed from those presented in the DSM-IV-TR. However, an alternative model for the diagnosis of personality disorders has been placed in Section III of the DSM-5, and the construct of "identity" has been integrated as a central diagnostic criterion for personality disorders (1). The focus of this article is on the relevance of identity problems to understand personality pathology during adolescence; we will also demonstrate how identity disturbance in adolescents can be assessed and treated.

Identity Disturbance During Adolescent Development

The consolidation of a stable identity is one of the core developmental tasks of adolescence. According to Erikson's definition (2), *identity* is a fundamental organizing principal that develops constantly throughout life and that provides a sense of continuity within the self and in interaction with others ("self-sameness"); it is also a frame through which to differentiate the self from others ("uniqueness") and to function autonomously. A well-integrated identity with flexible and adaptive functioning plays a role in self-esteem, in the realistic appraisal of the self and others, and in the development of insight into the effect that one has

on others. Identity is a basis of self-reflective functioning that provides predictability and continuity of functioning within a person, across situations, and across time (3).

Erikson (2) was the first to formulate concepts of identity crises and identity diffusion as characteristics of normal and pathological personality development. An identity crisis occurs as a result of a lack of confirmation by others of the adolescent's changing identity. During such a period, there is a lack of correspondence between the view of the adolescent by his or her immediate environment and the adolescent's changing self-experience (4). Identity crises are normal elements of adolescent development (5). During identity crises, the continuity of the self remains across situations and across time, despite experimentations with different roles. Such crises usually resolve into a normal and consolidated identity with flexible and adaptive functioning (3).

In contrast, identity diffusion is seen as the core of personality pathology. It implies that there has been a lack of integration of the concepts of the self and significant others (6,7), and it leads to a broad spectrum of maladaptive and dysfunctional behaviors:

- The leading symptoms are chronic emptiness, superficiality, poor anxiety tolerance, and a lack of impulse control (8).
- The normal capacity for self-definition is lost, so emotional breakdowns occur at times of physical intimacy, occupational choice, or competition (1).
- The lack of a stable self-definition leads to a threatening sense of danger of fusion or of loss of identity in intimate relationships. Thus, one of the interpersonal consequences of identity diffusion is the incapacity for intimacy in relationships; this is one of the four core criteria presented in the alternative model given in the DSM-5 (9).
- Under the influence of a peak affective state, there is a serious loss of the normal capacity for self-reflection and mentalization (10). The person is not able to assess the affective state from the perspective of an integrated sense of self.

Assessment of Identity Development

The Self-Report Questionnaire Assessment of Identity Development in Adolescence (AIDA)

Because identity development is regarded as the key feature in emerging personality disorders during adolescence, we developed the self-report questionnaire Assessment of Identity Development in Adolescence (AIDA) (11) to differentiate between healthy identity integration, identity crisis, and identity diffusion. This instrument has proved to be a reliable, valid, and time-efficient inventory that represents a dimensional concept of healthy and impaired personality development. It can also be used as a screening instrument to evaluate the outcomes of specific treatments for identity disturbance, such as Adolescent Identity Treatment (AIT). AIDA has been translated into 15 different languages, with each translation focusing on thorough cultural adaption (12).

AIDA is a 58-item self-report questionnaire for adolescents and young adults that assesses identity development in the two dimensions of continuity and coherence.

Continuity/Discontinuity and Coherence/Incoherence

Characteristics that help us to differentiate identity diffusion from normal identity are found along the continuums of continuity/discontinuity and coherence/incoherence (8).

Continuity is the basic emotional experience of the self as existing fully in the moment and across time, which is also known as the "I." It is characterized by the experience of a subjective self-sameness within a moment and across time and that exists in the past, the present, and the future (i.e., ego stability). This is associated with identity-stabilizing goals, talents, roles, and relationships within an accessible emotional context.

Coherence is the narrative experience of the self that is articulated in the awareness of the social context; this is also known as the "Me," and it is defined as being identical with oneself. It is characterized by the individual being consistent and genuine rather than suggestible or superficial. It requires good access to cognitive awareness, which is particularly evident in the presence of well-integrated and differentiated mental representations, which allow for the maintenance of the self in the context of others (i.e., ego strength).

For an individual with a normal identity, coherence and continuity are both present, so the experiences of "I" and "Me" are integrated and do not feel distinct or distant. This state is associated with the capacity for in-depth interpersonal relationships, with good self-differentiation and other differentiation, with mutuality and reciprocity, and with the maintenance of self within the social context.

AIDA has shown good reliability, with an alpha of .94 for the total scale of identity integration versus identity diffusion as well as alphas of .86 and .92 for the two primary scales discontinuity and incoherence, respectively. The total score differentiated significantly between controls and patients with personality disorders, with effect sizes of more than two standard deviations (13).

Treatment of Identity Pathology During Adolescence

Adolescent Identity Treatment

In 2000, Paulina Kernberg and coworkers illustrated a model for understanding identity pathology in children and adolescents (3). Their primary concern was differentiating those adolescents with normal identity crises from those with identity diffusion. In 2005, a clinical supervision study group co-led by Paulina Kernberg and Pamela Foelsch began to develop a treatment approach to facilitate the integration of identity with consideration for the developmental tasks and capacities of adolescents; the results were later developed by our group into AIT (14).

AIT is a therapeutic approach to the treatment of personality disorders in adolescents that includes both psychodynamic and integrative perspectives. AIT specifically focuses on identity; it integrates modified elements of Transference-Focused Psychotherapy (15) with psychoeducation, behavior-oriented home plans, and work with parents to support the therapeutic process of the adolescent. In contrast with typical psychoanalytic treatments, AIT has characteristics that include the use of a treatment contract; emphasis on affects in the here and now, the preferred technique of clarification (and less interpretation), the combination with behavioral and psycho-educational elements like a home plan, and the inclusion of parents, school, peer-groups, and siblings).

The Theory Behind the Model: Object Relations Theory

In modern object relations theory, there is a basic assumption that early experiences with caregivers, particularly those within intense affect states, lead to the development of internalized mental representations of the self and a mental representation of the other (7,16). Under conditions of peak affect activation—whether they are of an extremely positive and pleasurable nature or an extremely negative and painful one—specific internalizations take place and are framed by the dyadic nature of the interaction between the baby and the care-taking person. This leads to the development of specific affective memory structures with powerful motivational implications. Kernberg (7,15,17) stated that dyadic structures constituted by a representation of the self, interacting with a representation of a significant other, under the dominance of a peak affect state explain adult pathology that is based on early developmental experiences. These basic dyadic units are heuristic devices that facilitate the recognition of shifts in affective experience of the self and others in therapeutic "here and now" moments.

The Kernberg model (15,17) assumes that positive and negative affective memories are built up separately during the early internalization of these intense caregiving experiences. Later on, they are actively split or dissociated from each other in an effort to maintain an ideal domain of experience of the relationship between the self and others and to escape from the frightening experiences of negative affect states. Negative affect states tend to be projected and to evolve into the fear of "bad" external objects, whereas positive affect states evolve into the memory of a relationship with "ideal" objects. It is proposed that this early split experience protects the idealized experiences from contamination with the bad ones until a higher degree of pain tolerance and a more realistic assessment of external reality, particularly under painful conditions, can evolve.

Basic Principles of Adolescent Identity Treatment

The basis of AIT is to clear blockages of normal development—specifically of identity—to produce improvements in behavioral, affective, and social functioning. The normal development of the integration of positive and negative aspects of self and others can become blocked as a result of constitutional factors, environmental factors, or their combined interaction. The psychotherapeutic interventions of AIT target both constitutional and environmental contributions to help clear the developmental blockages in adolescents who suffer from identity diffusion.

Clearing Blockages

During normal adolescent development, situations that evoke an identity crisis create temporary confusion regarding the individual's identity. This confusion generally resolves naturally as the adolescent integrates the contradictory images of the self that were evoked from the discontinuities between the self and others' views of the self. These occur most noticeably in the context of major life choices (e.g., intimacy, career choice, competition, psychosocial). However, it is the everyday situations that the adolescent encounters that evoke the daily decisions that help to define the self through actions. Most of these occur with little awareness or conflict. For example, adolescents make decisions about what they will wear, who they will spend time with, where they will go, and what they will do. Together, these actions define who the adolescents are, how they wish to appear to others, and how others actually see them. The working-through process occurs relatively smoothly and as part of the normal discourse with friends, trusted adults, and family members. In adolescents with identity diffusion, the normal ability to resolve the

contradictory self-images evoked during an identity crisis is blocked by the maintenance of various defenses, particularly the split of the positive and negative representations of the self and of the representations of others.

AIT focuses on clearing these blockages through the use of the therapeutic relationship as well as interpretive work (i.e., using the techniques of clarification, confrontation, and, ultimately, interpretation) so that normal development can occur at an age-appropriate level.

Contract Setting

The purpose of setting a treatment contract is to provide a clear frame within which deviations can be observed, clarified, confronted, and ultimately interpreted. Although most aspects of the individual contract will remain between the therapist and the adolescent (e.g. regular attendance at therapy sessions, no drugs before sessions, report self-cutting), there are some modifications that need the inclusion of the parents to facilitate support for the treatment and the individual contract (e.g., remind the child to go to therapy, help the child to control drug abuse). There is also a need for increased direct environmental interventions by those who work with adolescents (e.g., pediatricians, teachers, social workers). Finally, it is very important to develop and implement the "Home Plan", which represents the family contract as it applies to rules at home.

Home Plan

The Home Plan is based on the integration of psychodynamic and family systems theory, and it involves primarily cognitive-behavioral techniques. The plan incorporates aspects that the adolescents and their parents have identified as problematic, and it is organized and prioritized by the therapist. Prioritization follows the standard AIT hierarchy, with self-harm being at the top of the list. The therapist must judiciously choose which norms to support and include in the Home Plan; he or she will need to decide which of these will be targeted for change. Although the primary emphasis is on controlling the adolescent's self-destructive behavior and engendering a sense of respect for the self and others, ineffective patterns of communication by the parents are also addressed. Parents can also include expectations for their own behavior in the home plan, such as "no nagging" (i.e., ask only once and then leave it to the adolescent to respond). The Home Plan serves the function of organizing the overt behavioral interactions between the adolescent and his or her family. It provides rewards and consequences for behavior; it offers an opportunity to clarify distortions in the perception of reality (particularly the discrepancies between the adolescent and the parents); and it encourages self-reflection and personal responsibility for the actions and the contributions to interactions of each party while remaining flexible. Furthermore, the Home Plan provides a "helping ego" for the family by providing structure and an explanatory model for understanding the adolescent's actions and world view. Finally, the Home Plan supports motivation and positive behaviors by helping to establish a sense of competence as the adolescent increases his or her ability to contain and manage his or her affect in a more effective way. In essence, it represents the reality principles present in the family.

Strategies for Treatment

With AIT, there are a few key strategies that guide the general approach and specific actions; these are articulated in the tactics and techniques of this strategy. In general, these aspects are consistent with the object relation treatment model elaborated by Clarkin and colleagues (15,17).

Identifying the Dominant Object Relationship Dyads

The first strategy is to identify the dominant object relationship dyads as they are observed within the extra-transferential relationship and within the transference. Understanding these dyads help to elucidate the adolescent's awareness of them in interpersonal relationships and in the "here and now" interaction with the therapist. The therapist can do this with the use of a four-step process. The first step requires the therapist to experience and tolerate the confusion and the strong affects that are activated as the adolescent's inner world unfolds in the process. These affects are observed simultaneously within the adolescent's descriptions of his or her relationships with others (i.e., the extratransferential relationships) and his or her reactions to those relationships as well as within the transference itself (i.e., is the patient suspicious, interested, paranoid?). The second step requires the therapist to identify the dominant object relations. For example, the adolescent may characterize himself or herself as the "helpless victim" in the relationship with the "attacking other" which is also experienced in the therapist, who observes the adolescent feels like the victim attacked by the therapist. Once the therapist is clear about the activated dyads, they can then be shared with the adolescent (step three). However, this is only done after extensive clarification within the here and now of the affect and behaviors that are activated.

During the final step of the process, the therapist attends to the patient's reactions to the presentation

of the object relations that are present in the here and now, and returns to clarification to facilitate cognitive reflection, affect tolerance, and ultimately differentiation from the other (therapist) and integration (of self and other mental representations).

Transference and Countertransference

Adolescents maintain relationships with their parents, other family members, teachers, and peers. For adolescents with identity diffusion, these relationships are often distorted by the projections of their internal world. These projections are the transfer of the internal object relationship world onto the relationship in reality with the other person. Because these projections have more to do with the internal world than they do with objective reality, they create many interpersonal problems, which further contribute to the maintenance of identity diffusion.

Techniques in Adolescent Identity Treatment

Clarification

Clarification is understood as the therapist's invitation to the patient to explore and explain any information that is unclear, vague, puzzling, or contradictory. Clarification is particularly important, because the main affect of borderline patients is confusion. Often psychotherapists think that they have to understand their patients "without words" and without asking; they believe that it is a sign of understanding when they do not ask questions. However, with the technique of clarification, it is the opposite: the therapist shows that there are still things that are unclear and that he or she is also curious to truly understand the patient. He or she may say things like the following: "I didn't understand"; "Please explain that to me again"; and "If I understand you correctly, ..." The main message conveyed is that the therapist is truly interested in understanding what the patient means. By asking these questions, the therapist conveys the following ideas: "I am not perfect, and I need further explanation"; "I am honest, and I'm telling you that I don't yet understand"; and, "It's OK if someone is not perfect."

The specific areas to target with clarification are the affects, the object relationship dyads, and the various perspectives (i.e., with regard to the self, others, and time). The main goal of clarifying the affects is to facilitate the adolescent's ability to recognize when he or she is having an affective experience; he or she will also then be able to identify and name the affects and ultimately will develop the capacity to differentiate the locus of the origin of the affect (i.e., Is the locus of origin within the self or the other? Is it internal or external?).

Clarifying the object relationship dyads is one focus of treatment; with adolescents, this is an essential aspect of the developmental phase (i.e., the context of the task of differentiation from the family of origin and movement into the adult world). The focus of the clarification is on the differentiation of the self and other as well as the integration of the self-representation and other representations. This directly increases reflective functioning, because adolescents are encouraged to articulate their internal experience and to imagine the experience of the other. This facilitates increasing differentiation between the self and the other. Clarification allows the adolescent to develop awareness and a vocabulary of experience while identifying and tolerating the affects that emerge in the context of this increasing awareness and associated meanings.

Confrontation

The process of confrontation with an adolescent involves bringing the contradictory thoughts, feelings, and/or actions into the adolescent's awareness; this allows for their gradual integration, which results in improvement of affect and impulse tolerance, judgment, and interpersonal functioning.

The contradictory presentation is observed in the three channels of communication: the verbal, the non-verbal, and the therapist's countertransference. All of these aspects are used to assist the therapist's selection of what contradictory aspects of the material (i.e., thoughts, feelings, actions of the adolescent, as well as therapist countertransference) to confront the adolescent with and when to share these observed discrepancies. Confrontations are invitations to look at the contradictions in experience that have become more conscious during the clarification process. As indicated, sometimes these contradictions are within the adolescent's own experience, but often they exist between the adolescent's experience and therapist's experience. Usually these are tolerated best when they are provided tentatively, as hypotheses, about the observations and/or the meanings of these contradictions (e.g., "You tell me that you are not at all disappointed that your mother didn't call you on your birthday, but you struggle with tears. What do you think could this mean?") This process elucidates the areas of contradiction or inconsistency and brings them into the adolescent's awareness. It is used to mark specific aspects in the here and now of the adolescent's experience while simultaneously challenging the adolescent to reflect on his or her experience. The contradictions and inconsistencies, the defensive functions, and the unconscious motives are brought into conscious awareness and used to confront the adolescent's

distortions of reality. This further sets the stage for interpretation.

Interpretation

Like confrontations, interpretations are hypotheses offered to the adolescent for his or her consideration. Unlike confrontations, which aim to bring the contradictions into awareness, interpretations help adolescents organize and develop meaning for their thoughts and actions. Interpretations focus on the intrapsychic functioning, which has been understood through the earlier clarifications and confrontations around the material that is conflicted. The goal is to help articulate the relationship between the various aspects of the adolescent's conscious material and to link this with the inferred unconscious material that is exerting influence on the adolescent's motivation and functioning. The interpretation links the contradictions between the verbal and non-verbal information and the countertransference.

In contrast with the process used for adults, interpretation involves an attitude of play when working with adolescents. Because adolescents are in the transition from childhood to adulthood and because their cognitive abstract reasoning skills are continuing to develop, it is often useful to incorporate metaphors and stories into the interpretation process.

The therapist will systematically work toward the full interpretation by providing language to articulate the affective experience in the context of the activated object-relationship dyads. He or she will also offer alternative possibilities (i.e., explanatory hypotheses) in an effort to provide concrete options from which the adolescent may choose. For example, "Could it be that you feel a, b, c, or none of these feelings in the situation you described?"

Therapeutic Stance

There are three attitudes that optimally support the therapeutic process of AIT: 1) openness and acceptance within the treatment structure; 2) optimism (holding a positive mental representation of the adolescent); and 3) curiosity and interest in wanting to know the adolescent as a person (not just within the context of his or her pathology). Optimism is a general attitude that allows the therapist to engage therapeutically because he or she has a vision of the adolescent's potential and is able to imagine the patient in health. It has a counterpart within the adolescent, which we refer to as the minimum "one square millimeter" of desire to change in treatment. Both are required for a successful treatment to occur.

The therapeutic stance is composed of the factors associated with all good therapists (e.g., genuineness, warmth, empathy), but in this case emphasis is placed on certain aspects that are particularly relevant to adolescents. A therapist is fully present when the body language, affect tone, and language are consistent and integrated with the cognitive curiosity directed toward understanding the adolescent's experience in all areas, but with particular attention to the here and now relationship.

Although there are many techniques that will greatly facilitate the adolescent's ability to move from a position of identity diffusion toward normal identity development, there is a simple premise upon which all the techniques are based. Adolescents, like children, learn primarily through actions. Therefore, it is the therapist's actions that the adolescents experience. A therapist who is genuinely interested in and curious about an adolescent's experiences is modeling a way to productively engage interpersonally. On a deeper level, it is important to engage the adolescents in the areas of being curious and interested in themselves as well as in their relationship with the therapist. Clinically, therapists observe that adolescents with personality pathology have often lost the natural curiosity toward and interest in things that is usually a prominent characteristic of children and normal adolescents. The therapist needs to focus on increasing the adolescents' curiosity and interest in their own experiences.

Working With the Families

Working with parents is one of the core aspects that differentiates work done with children and adolescents from that done with adult patients. There are variations among therapeutic approaches to when and how to work with the parents of adolescents. Typical psychotherapeutic work with adolescent and young adults places the family work much more in the background. With AIT, however, the therapist must work with the parents and families to support the changes that will occur within the adolescents as the treatment progresses. To do this, the therapist's stance toward the family, in the absence of any egregious boundary violations (e.g., the presence of sexual or physical abuse), is one of general acceptance that the family members have been doing the best they can; they may just not necessarily be using the most effective strategies or acknowledging the real impact of the pathology of the adolescent. Even "good enough" parents can appear to be quite disturbed under the loading of the severe disorder of their child.

Even in very disturbed relationships, there are intense bonds between children and their parents. If

the therapist does not include the parents in the treatment process, he or she underestimates their influence on the interactions that take place in the home and that maintain the disorder. Therapists also overestimate themselves if they take full responsibility for the adolescent. If the parents are viewed as terrible and invalidating, then the therapist siding with the adolescent's view of the terrifying and persecutory parents may cause the adolescent to fantasize about the therapist as a better parent (i.e., a "savior"). This risk fosters and maintains a split internal structure as opposed to the treatment goal of integration.

Psychoeducation

With AIT, psychoeducation is provided to parents to promote an understanding of the normal developmental tasks of adolescence as well as of the areas in which their child is having difficulties. Four areas are typically addressed: 1) communication and relationship building and maintaining; 2) limit setting; 3) safety/rescue/judgment/autonomy; and 4) affect management.

Information about what is normative and usual for adolescents gives parents a frame of reference within which to understand the areas that are problematic for their child. Psychoeducation also provides an opportunity for parents to become aware of what they may not have acknowledged about the depth and breadth of their child's difficulties. In rare cases, it may also help those parents who are too eager to find dysfunction in their child to normalize their view and expectations.

Clinical Significance

For a long period of time, the assessment and treatment of adolescents' personality pathology was completely dependent on concepts and instruments that had been developed for personality disorders in adults. In this sense, the adaptation of Dialectical Behavior Therapy for the treatment of adolescents with Borderline Personality Disorder was a major breakthrough (18); it was followed, in recent years, by the adaptation for adolescents of other treatment approaches for adults, such as Cognitive Analytic Therapy (CAT), Mentalization-Based Therapy (MBT), or Emotion Regulation Training (ERT) (19-21). Using the psychodynamic approach Transference-Focused Psychotherapy (TFP) our working group integrated family systems theory, behavioral concepts, and psychoeducation into the integrative therapeutic approach of AIT, which is attuned to the specific needs and difficulties of adolescents with severe identity pathology. The inclusion of the family is seen as essential to the success of this treatment. The results of an initial pilot study are promising (14). As a next step, we plan to evaluate both the treatment outcomes and basic therapeutic processes of AIT as compared with DBT-A. The AIDA questionnaire can also be used as both a screening tool to detect emerging personality pathology in adolescence and an outcome measure to assess changes in identity disturbance from diffusion toward healthy identity integration.

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7.4 Erklärung

Ich versichere, dass ich die hier vorgelegte Dissertation „Erfassung und Behandlung von Adoleszenten mit einer Identitätsstörung“ nur mit den darin angegebenen Hilfsmitteln verfasst, alle Zitate gekennzeichnet und diese bei keiner anderen Universität und keiner anderen Fakultät der Universität Basel eingereicht habe. Alle Artikel sind peer-reviewed und in englischsprachigen Journals publiziert resp. für eine Publikation akzeptiert.

Basel, den 24. Oktober 2014

Emanuel Jung